

# Hospital and FQHC Collaboration: *Findings and Opportunities*

---

MARCH 2012

---



## TABLE OF CONTENTS

<b>Executive Summary</b> .....	<b>3</b>
<b>Promising Practice: Community or Regional Health Councils</b> .....	<b>4</b>
Health Care Coalition of Lafayette County.....	4
The Springfield-Greene County Regional Health Commission.....	5
The Mid-America Regional Council Regional Health Care Initiative.....	6
St. Louis Regional Health Commission and St. Louis Integrated Health Network.....	7
<b>Promising Practice: Community Medication Assistance Program</b> .....	<b>9</b>
<b>Promising Practice: Urgent Dental Care Clinic</b> .....	<b>12</b>
<b>Promising Practice: Our Healthy Start Program</b> .....	<b>13</b>
<b>Promising Practice: Collaborative Women’s Health Initiatives</b> .....	<b>14</b>
<b>Promising Practice: Community Referral Coordination Program</b> .....	<b>16</b>
<b>[Appendix] Results of Literature Search form Articles on Collaboration Between Hospitals and FQHCs</b> .....	<b>18</b>

## PARTICIPANTS

<b>Donald J. Babb</b> CEO Citizens Memorial Hospital	<b>Herb B. Kuhn</b> President and CEO Missouri Hospital Association	<b>Joseph Pierle</b> CEO Missouri Primary Care Association
<b>John W. Bluford</b> President and CEO Truman Medical Centers Inc.	<b>Michael McManus</b> CEO Touchette Regional Hospital	<b>Leslie Porth</b> Vice President of Health Planning Missouri Hospital Association
<b>Gloria Crull</b> CEO Family Health Center	<b>Bryant McNally</b> Vice President of Rural Services and Regulation Missouri Hospital Association	<b>Alan Stevens</b> CEO Community Health Center of Central Missouri
<b>John M. Dawes, FACHE</b> President and CEO Bothwell Regional Health Center	<b>Brooks Miller</b> CEO Jordan Valley Community Health Center	<b>Chris Stewart</b> CEO Katy Trail Community Health
<b>Marcia R. Dial</b> CEO Scotland County Hospital	<b>Palmer R. “Nick” Nichols</b> Vice President of Membership Services Missouri Hospital Association	<b>Paul Taylor</b> CEO Ozarks Community Hospital
<b>Ben Ernst</b> CEO Northwest Health Services	<b>Daniel O’Neill</b> Director of Government Affairs and Health Center Development Missouri Primary Care Association	<b>Karl Wilson</b> CEO Crider Health Center
<b>Hilda Fuentes</b> CEO Samuel U. Rodgers Health Center	<b>Leah Osbahr</b> CEO Washington County Memorial Hospital	<b>Susan Wilson</b> COO Missouri Primary Care Association
<b>Andy Grimm</b> CEO Northeast Missouri Health Council		

## EXECUTIVE SUMMARY

The environment faced by hospitals and federally qualified health centers is rapidly changing. The promises of health reform and its impact on all hospitals and FQHCs are approaching at an ever increasing speed. The creation of accountable care organizations and health homes are placing the relationship of providers into the crosshairs. To better prepare our members for these changes, the Missouri Hospital Association and the Missouri Primary Care Association have prepared this report detailing promising practices for collaboration between hospitals and FQHCs. The programs and initiatives shared in this document may not be feasible for each and every community. However, they do provide a starting point for the dialogue that is necessary to a successful working relationship. In addition to the promising practices, the core issue driving the work of this project concerns relationships.

The relationships and dynamics between hospitals and FQHCs vary dramatically statewide. In the urban areas, there is a better working relationship between hospitals and FQHCs. These relationships have led to several joint initiatives that have successfully benefitted the operation of all the partners. However, the situation is much different in rural areas. The culture and mindset of competition for resources and patients is very ingrained. In particular, some hospitals overestimate the value of the federal incentives that FQHCs receive and believe that FQHCs should only serve the uninsured or only provide dental and behavioral health services. On the other hand, some FQHCs discount the value of rural health centers run by rural hospitals and believe the RHCs' financial incentives exceed their own. In addition, there are incentives for FQHCs to expand into small communities regardless of current access points such as RHCs. The creation of additional service delivery sites in outlying communities has consistently caused issues for hospitals and FQHCs. The promising practice of community or regional health councils may provide an initial strategy to address several of these rural concerns. Other strategies to improve the relationships include the following.

- provide education for hospital leaders about FQHCs' financing and roles in the health care system
- provide education for FQHC leaders about the role, mission and financing of RHCs and rural hospitals, particularly critical access hospitals
- encourage host site visits by others to learn about each's service niche and functions

While we hope that these promising practices may provide insight into possible solutions faced by others, we believe the key result of our work is to highlight the need for the leaders of hospitals and FQHCs to come together and begin a dialogue that puts the patient and the community first. Each has an important role to fill, and it is incumbent upon the leaders to find solutions that serve the needs of their patients and their communities.

## PROMISING PRACTICE: COMMUNITY OR REGIONAL HEALTH COUNCILS

Community or regional health councils engage key health care stakeholders with leaders in local government, academia, philanthropy and/or business. These councils help to generate and sustain collaborative initiatives to address health issues.

Each community health council is different in its genesis, makeup and specific goals. However, they all seem to have the same core missions — to improve communication and seek solutions that improve access to care and health outcomes for their populations.

The health councils identified during this project are described below, along with their recent major initiatives. Each grew from the recognition of community needs, leadership provided by key players and grant support from government and/or philanthropic sources.

The primary value of a health council lies in the shared perspective that develops when the entities responsible for public health and health care in a region start to meet regularly to identify issues and look for solutions. They learn more about one another and have a better understanding of each others' motives, how each serves the community, the problems they each face and the resources they can bring to bear to improve health. This collegial relationship can then generate joint initiatives to address specific problems.

In contrast, in areas without health councils, there is no forum for deliberate efforts to identify issues and align resources to address them. In these areas, there tends to be less trust and more of a perception that health care providers are strictly competitors as they invest in duplicative physical plants and services while trying to “capture” each others' patients. These attitudes have obvious implications for the continuity and quality of patient care, as well as for health care costs.

---

### Health Care Coalition of Lafayette County

The Health Care Coalition of Lafayette County (HCCLC) began as a community health improvement pilot site funded by a grant from the Missouri Department of Health and Senior Services to the Lafayette County Health Department. In 2008, the coalition became an independent not-for-profit organization.

The coalition's mission is to provide leadership in securing comprehensive services across the continuum of care. Seven agencies make up the coalition's executive board — Lafayette County Health Department, Lafayette Regional Health Center (LRHC), Rodgers-Lafayette Dental and Health Center (a FQHC), Care Connection for Aging Services, Pathways Community Behavioral Healthcare Inc., and the 4-Life Center. The current funding mix includes grants from Health Resources and Services Administration, the Missouri Foundation for Health and local foundations.

A community health needs assessment was conducted in 2008 under the leadership of the Lafayette County Health Department. The coalition is preparing an updated assessment in conjunction with the Missouri Valley Community Action Agency. Based on the earlier assessment results, the HCCLC board established the following priorities.

- implement and oversee the expansion and delivery of a system of primary care, dental care, behavioral health, health and wellness prevention programs, and school-based programs
- monitor and make recommendations on the availability and delivery of all primary health and mental health services in Lafayette County, with a specific emphasis on ensuring access to health care

- offer a rural health insurance plan for area employers with a workplace wellness component that decreases insurance premiums over time
- determine the feasibility of establishing a Center on Aging to meet the comprehensive health care needs of elders in Lafayette County and surrounding areas
- develop a comprehensive health information technology plan that addresses the needs of all health providers throughout the county
- continue to provide and expand programs that promote healthy habits to combat chronic disease

Three committees, Health Information Technology, Healthy Lifestyles and Social Services, were formed to seek out grants and contracts for programs to address these issues. Their current successes include the following.

- A partnership between Pathways Behavioral Health and LRHC provides mental health services via a two-way telehealth connection. Patients can receive both behavioral health and primary care services in a single visit to either provider.
- The creation of the Rural Missouri Health Co-op offers an affordable health insurance option for Lafayette County employers. Six companies are participating in the plan.
- The groups support providers moving to e-prescriptions, as well as an emergency department information system at LRHC.
- The development of an HIT Network Development grant application would allow limited exchange of health information between network members, plus two other hospitals in the region. The coalition leveraged matching funds from its partners to apply for \$900,000 in federal funds.

## Contact Information

### Toniann Richard

Executive Director

Health Care Coalition of Lafayette County

811D Highway 13

Lexington, MO 64067

660/259-9019

[www.hccnetwork.org](http://www.hccnetwork.org)

## The Springfield-Greene County Regional Health Commission

The Springfield-Greene County Regional Health Commission was developed in 2009 as a nonprofit corporation and public charity “to guide the efforts of business, community, health care and governmental leaders in order to effectively and sustainably address and improve the community’s health. Specifically, the Health Commission aims to support collaborative processes that address access to care and health outcomes for underserved populations in southwest Missouri.”

The Health Commission received seed money from the Missouri Foundation for Health and has served as a forum for identifying problems and as a nexus for collaborative initiatives in Springfield. It is chaired by the Springfield-Greene County health director and includes representatives of the Jordan Valley Community Health Center (JVCHC is a federally qualified health center), each Springfield hospital, The Kitchen Clinic (a free clinic run by a charitable organization), the Chamber of Commerce, United Way, Missouri State University, city and county officials, and others.

Among the Health Commission's accomplishments is the publication of a community health assessment report that includes public health data from various sources; data from hospitals, emergency departments and safety-net providers; and the results of a community-wide health survey. The report is available at [www.springfieldmo.gov/health/documents/ACACFinalAssessment.pdf](http://www.springfieldmo.gov/health/documents/ACACFinalAssessment.pdf).

The commission has coordinated the development of a collaborative Community Medications Assistance Program to facilitate access to medications for low-income, uninsured/underinsured patients through pharmaceutical company assistance programs and partnerships with local pharmacies. This program pools resources from the Missouri Foundation for Health, the hospitals and the Jordan Valley Health Center to enhance efficiency and expedite the process for patients to obtain their medications. The program goals are to alleviate chronic conditions and reduce emergency department utilization and hospitalizations by ensuring that patients receive appropriate medications in a timely manner.

### **Contact Information**

**Robert Lunn, MHA, Ph.D., CEO**

The Health Commission

P.O. Box 8913

Springfield, MO 65801

417/851-1563

[bob.lunn@thehealthcommission.org](mailto:bob.lunn@thehealthcommission.org)

[www.thehealthcommission.org](http://www.thehealthcommission.org)

---

### **The Mid-America Regional Council Regional Health Care Initiative**

The mission of the Mid-America Regional Council (MARC) is to promote regional cooperation and develop innovative solutions. This nonprofit association of city and county governments serves as the metropolitan planning organization for the bistate Kansas City region. MARC is governed by a board of local elected officials and serves nine counties and 120 cities. It is funded by federal, state and private grants, local contributions and earned income. A major portion of its budget is passed through to local governments and other agencies for programs and services.

One component of MARC is the Regional Health Care Initiative (RHCI), whose members include all the major safety-net providers for health and mental health services in the nine-county bistate metropolitan area. Supported by the Health Care Foundation of Greater Kansas City and the REACH Foundation, RHCI holds a monthly meeting for its Safety Net Collaborative to cultivate working relationships. Its mission is to improve and increase access to health care for low-income, uninsured and underinsured residents of the bistate Kansas City region. The report of its first assessment of safety-net capacity, published in February 2010, is available at [www.marc.org/healthinitiative/assets/RHCI-Capacity-Report.pdf](http://www.marc.org/healthinitiative/assets/RHCI-Capacity-Report.pdf). Several subcommittees are devoted to addressing specific aspects, such as access to specialty care and after-hours care coordination.

The Safety Net Collaborative focuses on issues such as these.

- reducing ED use for primary care by providing evening and weekend clinic services
- access to specialty care for uninsured/underinsured patients
- infrastructure to support core services
- marketing FQHC services

The Metropolitan Mental Health Stakeholders, another subinitiative, consists of consumer advocates, mental health professionals and organizations, public administrators, correctional institutions and the legal community. It also meets monthly to collaborate on how to improve behavioral health care services in metropolitan Kansas City.

## **Contact Information**

### **Scott Lakin, Director**

Regional Health Care Initiative  
c/o Mid-America Regional Council  
600 Broadway, Suite 200  
Kansas City, MO 64105  
816/474-4240  
816/701-8288 direct  
[slakin@marc.org](mailto:slakin@marc.org)  
[www.marc.org/healthinitiative](http://www.marc.org/healthinitiative)

---

## **St. Louis Regional Health Commission and St. Louis Integrated Health Network**

The St. Louis Regional Health Commission was formed in 2001 in response to the closure of St. Louis Regional Hospital and an urgent funding crisis for safety-net health care services. Its mission is to improve access to care, reduce health disparities and improve health outcomes in the St. Louis region. The 19 appointed commission members represent government entities, the health sector and community leaders. There also is a 60-member advisory board made up of health care providers and community representatives.

The commission's main priorities are related to the financial sustainability of the health care safety net. It coordinates an annual pool of approximately \$25 million in disproportionate share funds, received through an agreement with the state. It is charged with creating and implementing a business plan to restructure safety-net care in St. Louis. Details of its many activities and accomplishments can be found at [www.stlrhc.org](http://www.stlrhc.org).

In response to a recommendation from the St. Louis Regional Health Commission that a permanent network of safety-net health care providers be formed to better integrate and coordinate services, the Integrated Health Network (IHN) was formed in 2003 with support from HRSA.

IHN is an alliance of primary and specialty medical care providers that serve the uninsured and underinsured. Its board of directors is made up of the CEOs of four FQHCs, two medical schools, St. Louis ConnectCare, Crider Health Center and the St. Louis County Department of Health. Both the Missouri Primary Care Association and the St. Louis Regional Health Commission serve as technical advisors to IHN.

The overarching goal of IHN is to ensure access to health care for uninsured and underinsured children and adults through increased integration and coordination of a safety net for health care. IHN providers serve 200,000 individuals in the St. Louis region each year for primary care through more than 400,000 encounters. IHN manages several key collaborative initiatives to strengthen the health care safety net in St. Louis. The Community Referral Coordinator program, which began in 2007, places referral coordinators in hospital EDs to connect nonemergent patients with primary care providers for follow-up and preventive care. It focuses on serving Medicaid and uninsured patients, with the goal of improving their access to regular care and decreasing ED usage and hospital admissions. A secondary goal is to decrease the no-show rate in the community

health centers, to use their staff more efficiently and reduce costs. The program has expanded to include coordinators in the following hospital EDs.

- Barnes-Jewish Hospital
- Christian Hospital
- Saint Louis University Hospital
- SSM Cardinal Glennon Children's Medical Center
- SSM DePaul Health Center
- SSM St. Mary's Health Center
- St. Louis Children's Hospital

A current pilot project is extending the CHC program's mission to include making referrals for inpatients, particularly Medicare patients, to the community health centers upon discharge. This approach is expected to enhance continuity of care and decrease hospital readmission rates.

The second large collaborative initiative managed by IHN is the St. Louis Network Master Patient Index (NMPI). This health information exchange is in the implementation phase and will include most of the major safety-net providers in St. Louis City and County, including the community health centers, the St. Louis County Department of Health primary care centers, St. Louis ConnectCare and seven hospital EDs. When fully implemented, it will enable the secure exchange of electronic clinical information between health center and ED clinicians; identify nonemergent Medicaid and uninsured ED patients who do not have an identified primary care physician; provide a messaging system to facilitate referrals, consultations and notifications; and enable aggregation of individual patient information across member organizations.

The goals of the NMPI are to help connect patients with a medical home, with the ultimate goal to decrease fragmentation of care and inappropriate utilization of EDs for primary care.

IHN also is taking an active role in efforts to increase the understanding and respect between hospitals and community health centers. This year, IHN coordinated regional publicity for National Health Centers Week and encouraged each health center to hold an open house and invite hospital CEOs and chief medical officers to tour their facilities and meet their staff. IHN, along with multiple partners, also is conducting a marketing campaign for community health centers and promoting the development of standardized intake procedures for health centers and other service agencies to minimize confusion and streamline the referral process.

Looking to the future, the IHN board has developed a Reform Ready Strategic Plan to meet the challenges and opportunities presented by national health care reform during the next several years.

## **Contact Information**

**Bethany Johnson-Javois**

CEO

St. Louis Integrated Health Network

1520 Market St., Ste. 4034

St. Louis, MO 63103-2625

314/657-1483

[www.stlouisihn.org](http://www.stlouisihn.org)

# PROMISING PRACTICE: COMMUNITY MEDICATION ASSISTANCE PROGRAM

## The Springfield-Greene County Regional Health Commission

### THE PROBLEM

A rising number of adult patients must go without their prescribed medications because of increasing drug costs and lack of insurance coverage. Individuals without health insurance made 23 percent of the visits to Springfield hospital emergency departments in 2009 and 20 percent of the visits to the four major safety-net primary care clinics.<sup>1</sup>

Without medication, patients with serious chronic health conditions can lose the ability to manage their conditions and are more likely to suffer serious complications. Patients who cannot afford prescriptions for acute conditions such as pneumonia may deteriorate quickly. Lack of access to needed medications decreases patients' quality of life and may lead to more ED visits and hospitalizations, resulting in increased long-term costs for both patients and providers.

In the past, many health care providers gave patients drug samples dropped off by pharmaceutical sales representatives, but this approach was not optimal to meet the patients' needs or use resources efficiently. Another option is for patients to participate in pharmaceutical company prescription assistance programs, available for uninsured patients who meet certain income guidelines. Each company's program is unique, and the guidelines and application process can vary greatly. More than 2,500 drugs are potentially available through these programs, so it is very difficult for providers to know about all the programs that exist, which drugs they cover, and how to access them. It is also difficult for patients to navigate the enrollment process on their own.

Until recently, each of the major health care providers in Springfield had its own approach to this problem. About two years ago, one hospital system developed a program to assist patients in identifying and applying for pharmaceutical company assistance programs. JVCHC had a similar program in place, and the other safety-net providers continued to address the issue in various ways.

### THE PARTNERS

Springfield-Greene County Health Commission, St. John's Health System, CoxHealth System, JVCHC and the Kitchen Clinic

### THE PROMISING PRACTICE

The two major health systems, JVCHC and the Kitchen Clinic came together through the Springfield-Greene County Regional Health Commission to combine and expand the existing assistance programs to achieve economy of scale and make them effective throughout the health care system. They created the Community Medication Assistance Program (CMAP), which "seeks to improve the health and lives of low-income patients with no prescription coverage, while relieving the burden on the community's health care system through more appropriate use of medical services."

The Health Commission manages the program through its CMAP Advisory Board, which meets once or twice a month. The advisory board consists of a physician, a pharmacist and an administrator from each of the four participating entities. It is co-chaired by the Health Commission CEO and a highly respected local physician.

JVCHC folded its assistance program resources into CMAP and with contributions from St. John's, CoxHealth and the Missouri Foundation for Health (through a grant to the Health Commission), the operating budget for the first year was set at \$690,000. Six medical management staff from St. John's Health System were contracted to manage the day-to-day operations. Software was purchased that enables the staff to search for the specific drugs covered by pharmaceutical company assistance programs and the conditions under which patients may receive them.

CMAP is being implemented in two phases. Phase 1, which began July 15, 2011, is for patients with chronic diseases who need assistance in applying for pharmaceutical company programs. Phase 2, which began October 1, 2011, will provide assistance with a one-time fill of medications from a specific formulary and is not limited to patients with chronic disease.

#### Eligibility criteria for Phase I

- Patient is receiving primary care from a provider in Springfield or Greene County.
- Patient has a diagnosis of asthma, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, chronic depression, diabetes or hypertension.
- The patient's household income is less than 200 percent of the federal poverty level.
- The patient does not have any insurance coverage for prescription drugs.

The referral process involves a preliminary screening by the provider who faxes a referral form to CMAP. The form includes patient identifying information, basic information related to the program criteria (age, diagnosis, household size and income) and the prescribed medication(s) (no controlled substances). The CMAP staff searches for the appropriate pharmaceutical company program(s) for the prescribed drug(s) and completes the application(s). If necessary, CMAP staff contacts the patient via telephone to get more information. When the applications are complete, CMAP staff faxes them to the prescribing provider for signature, and the provider faxes them back.

If approved, the drugs are mailed to the physician's office/clinic or directly to the patient's home, depending on the specific drug and company program requirements. If the company declines to provide the drugs, CMAP informs the patient and provider.

Each patient's eligibility will be reviewed annually, but there is no time limit on the participation of qualified individuals.

For Phase 2, the program attempts to address situations in which patients cannot afford medications for an acute illness that, if left untreated, may result in hospitalization (e.g., pneumonia). It also will help some patients with chronic diseases while they wait for the arrival of their first medications from pharmaceutical companies through CMAP Phase 1 because this process can take a month or more.

CMAP will cover a free "first fill" of specific medications through an agreement with a local pharmacy provider, which will provide the drugs at a substantial discount. The formulary will be limited and will mostly consist of generic or relatively inexpensive drugs. Patient referrals will be made and eligibility determined through the same process used for CMAP Phase 1, and patient outcomes will be tracked to evaluate the program.

### **THE RESULTS**

The CMAP planning process included a one-year pilot study by St. John's Health System. The health care utilization of 176 patients was compared before and after they participated in the prototype program. The results were striking, with a 21 percent overall reduction in utilization, measured by the number of patient encounters. The patients served by the program had 54 percent fewer inpatient admissions, 30 percent fewer visits to the ED, 17 percent fewer physician office visits and 4 percent fewer urgent care clinic visits than the preceding year.

Based on these results, the Health Commission anticipates as much as \$2 million in annual savings to the health care system, which will more than offset the \$690,000 operating costs of the program. CMAP's effectiveness and cost efficiency will continue to be evaluated on an ongoing basis, and decisions about future funding will be made based on the outcomes.

**Contact Information****Robert Lunn, MHA, Ph.D., CEO**

The Health Commission

P.O. Box 8913

Springfield, MO 65801

417/851-1563

*bob.lunn@thehealthcommission.org**www.thehealthcommission.org*

*<sup>1</sup>“Finding a Voice: A Description of Health Care for the Underserved in Our Community,” a report of The Health Commission of Springfield, July 2010.*

## PROMISING PRACTICE: URGENT DENTAL CARE CLINIC

### Jordan Valley Community Health Center, Springfield

#### THE PROBLEM

Acute dental pain is the most common presenting symptom for patients visiting hospital EDs in Springfield. Adults in the area who do not have dental insurance have very limited access to care. If acute symptoms are not addressed, patients' productivity and general health can suffer, and they may return to the ED for additional care.

#### THE PARTNERS

The Jordan Valley Community Health Center maintains a dental clinic at its main location in Springfield, with a 11.4 provider FTE. The clinic is extremely busy, primarily serving a large pediatric Medicaid population. Of the 27,595 dental visits to JVCHC in 2009, 82 percent of the visits — 22,600 — were children ages 0-18 years. Medicaid was the source of coverage for 90 percent of the patients. Of the remaining patients, 4 percent had private insurance, and 6 percent were uninsured.<sup>1</sup>

The EDs at Cox Hospital North, Cox Hospital South, St. John's Medical Center and Ozarks Community Hospital all serve the emergency health care needs of Springfield residents.

#### THE PROMISING PRACTICE

Patients with acute dental pain who do not have dental insurance or a regular source of dental care can access urgent dental care through the JVCHC clinic. Four days a week, the clinic devotes one dentist and two dental chairs to urgent care. ED physicians may refer patients via fax or phone call. Referrals also can come from primary care providers and dentists in private practice. Patients may also call directly or stop by the dental clinic. They will generally be seen that day or the next.

A fixed fee of \$75 is charged for the first visit, which includes tooth extraction if necessary. The patient also is charged \$75 per visit for any follow-up care. This flat fee enables JVCHC to maintain the program in the absence of other payment sources for these patients.

#### THE RESULTS

Since the Urgent Dental Care program began in February 2009, more than 2,000 patients have received treatment.

#### Contact Information

**K. Brooks Miller Jr., M.A.**

President/CEO

Jordan Valley Community Health Center

618 N. Benton Ave., #100

Springfield, MO 65806-1105

417/851-1551

[www.jordanvalley.org](http://www.jordanvalley.org)

<sup>1</sup>"Finding a Voice: A Description of Health Care for the Underserved in Our Community," a report of The Springfield-Greene County Regional Health Commission, July 2010.

# PROMISING PRACTICE: OUR HEALTHY START PROGRAM

## Jordan Valley Community Health Center and St. John's Medical Center, Springfield

### THE PROBLEM

The Jordan Valley Community Health Center (JVCHC) provides prenatal care services through its primary care clinic. Until recently, the clinic did not have a specialist in obstetrics and gynecology on staff. Pregnant women who needed specialty care had to be referred elsewhere, and access to needed specialty care could be difficult for uninsured women and those covered by Medicaid. Continuity of care was difficult to maintain.

### THE PARTNERS

JVCHC and St. John's Medical Center

### THE PROMISING PRACTICE

Through the Our Healthy Start Program, which began in January 2010, two OB/gyn specialists from St. John's have been contracted to see patients part-time at JVCHC. They care for patients who have been evaluated by the JVCHC primary care practitioners (two advanced nurse practitioners and one certified nurse midwife) and found to need specialty care. These two physicians also are OB hospitalists at St. John's, so they are able to provide continuity of care to JVCHC patients who deliver babies there. In addition, St. John's maternal-fetal medicine specialists work at JVCHC one day per week to provide care for the highest-risk patients.

Another aspect of Our Healthy Start is the Centering Program at JVCHC. Centering is a group health care delivery model that includes assessment, education and support that is provided in a group and facilitated by a credentialed health care provider and a co-facilitator. The approach emphasizes culturally appropriate care and peer support. Groups of participating women receive education on topics like tobacco use cessation, nutrition, breastfeeding and services available for their babies after birth. Women are encouraged to socially connect with the other participants and also are connected with JVCHC pediatric services for their babies.

As an extension of this collaborative project, JVCHC has recently added a full-time OB/gyn physician to its staff, who also will have hospital privileges at St. John's. Two family practice physicians and two pediatricians from JVCHC will begin providing nursery coverage at St. John's in fall 2011 to provide better continuity of care for JVCHC prenatal patients and their babies.

Cox Health is working with JVCHC to expand Our Healthy Start to include clinicians from Cox South, the other major maternity hospital in Springfield. Currently, JVCHC patients who deliver at Cox South receive needed specialty services from physicians in the Cox residency program.

### THE RESULTS

In the first year of the program, 670 mothers participated. Hundreds of women are receiving the very best care as a result.

### Contact Information

**K. Brooks Miller Jr., M.A.**

President/CEO

Jordan Valley Community Health Center

618 N. Benton Ave., #100

Springfield, MO 65806-1105

417/851-1551

[www.jordanvalley.org](http://www.jordanvalley.org)

# PROMISING PRACTICE: COLLABORATIVE WOMEN'S HEALTH INITIATIVES

## Swope Health Services

### THE PROBLEMS

FQHCs provide quality primary care services to women who are uninsured or on Medicaid, but barriers to access often arise when specialty care is needed. Patients referred to a specialist may have difficulty scheduling or keeping an appointment and gaining access to discounted services. These issues can create delays in the diagnosis and treatment of time-sensitive conditions, which is especially problematic during pregnancy.

Low-income pregnant women may, for various reasons, not be able to plan very far in advance which hospital they will use for delivery. Women who are transported by ambulance are taken to whichever hospital is next on the list, and those who are being driven by a friend or relative may go to the hospital that is most convenient for the driver. This makes it difficult to ensure that the woman's prenatal records are available to the obstetrician who delivers the baby and also can lessen the likelihood of continuity of care for the mother after the birth.

For similar reasons, it can be difficult for low-income pregnant women to participate in traditional prenatal classes, which are usually designed to educate a cohort of pregnant woman, who are all at roughly the same stage of pregnancy, through a structured sequence of classes. Women who cannot come to every class can easily miss out on important information, with no way of catching up.

### THE PARTNERS

Swope Health Services, Truman Medical Centers Inc., and Research Medical Center

### THE PROMISING PRACTICES

Swope Health Services has developed several collaborative initiatives with hospitals to ease referrals for specialty OB/gyn services, coordinate with hospitals that provide maternity services and enhance prenatal education.

A pilot project with Truman Medical Centers Inc. that began in 2009 is designed to facilitate referrals for specialty women's health care. TMC sets aside certain time slots for Swope patients in three specialty clinics: high-risk OB, diabetes high-risk OB and gynecology. Two nurses in the women's health clinic at Swope have been granted secure access to TMC's electronic medical records system for appointment purposes. This allows the Swope nurse to consult with the patient and directly set up the appointment at the time that works best for her. The nurse also can help guide uninsured patients to the financial consultants at TMC before their appointments to see if they qualify for the sliding fee scale. These efforts are meant to ease the referral process for the patients so they are more likely to keep their specialty clinic appointments and have their high-risk conditions addressed.

When Swope OB patients enter the last trimester of pregnancy, their obstetrical records are automatically sent to both TMC and Research Medical Center. These two hospitals deliver a large percentage of the babies born to Swope patients, and providing the records to both ensures that they are available to the obstetricians attending the deliveries in most cases. This also helps to ensure that the patients are referred back to Swope after their deliveries rather than being sent somewhere else. OB patient records are sent to other hospitals upon request.

To address the need to make prenatal education classes accessible to and comfortable for low-income patients, Swope Health is partnering with RMC. The director of women's health services at RMC and one other staff

person have been providing prenatal education classes at Swope since September 2010. The classes, held for two hours every other Wednesday morning, are open to all Swope OB patients, regardless of where they plan to deliver. Classes are structured so that mothers can come as often as they are able, regardless of their stage of pregnancy. Lessons are tailored to those in attendance on a particular day.

### **THE RESULTS**

Approximately 12-16 referrals for specialty women's health services have been made each month through the Swope/TMC pilot project.

The prenatal classes conducted at Swope by RMC staff have averaged 8-10 attendees per class.

### **Contact Information**

**Jean Hosseini, MBA**

Service Line Administrator for Women's Health, Pediatrics and WIC

Swope Health Central

3801 Blue Parkway

Kansas City, MO 64130

816/923-5800

# PROMISING PRACTICE: COMMUNITY REFERRAL COORDINATION PROGRAM

## St. Louis Integrated Health Network

### THE PROBLEM

Patients often seek care in hospital EDs for nonemergent conditions or chronic health problems that could be managed better, and less expensively, in a primary care setting.

The “safety-net” population in St. Louis, defined as the uninsured and those on Medicaid, has increased dramatically in the last few years. The most recent assessment by the St. Louis Regional Health Commission estimated that there were 354,000 people in the safety-net population in 2009 (26 percent of the total population of St. Louis City and County), an increase of 13 percent from 2008. This increase was driven largely by the growing number of people without insurance, which went up 23 percent between 2008 and 2009. ED visits by members of the safety-net population increased by almost 25,000, or 9 percent, between 2008 and 2009.<sup>1</sup>

After ED treatment, many safety-net patients need follow-up care to address their ongoing health problems. Without an effective “hand-off” to a primary care provider, they may not receive the care they need and end up in the ED again, an expensive and ineffective cycle.

### THE PARTNERS

St. Louis Integrated Health Network, Family Care Centers, Betty Jean Kerr People’s Health Centers, Grace Hill Neighborhood Health Centers, Myrtle Hilliard Davis Comprehensive Health Centers, St. Louis County Department of Health, Barnes-Jewish Hospital, Christian Hospital, Saint Louis University Hospital, SSM Cardinal Glennon Children’s Medical Center, SSM DePaul Health Center, SSM St. Mary’s Health Center and St. Louis Children’s Hospital

<sup>1</sup>“Progress Toward Building a Healthier St. Louis: 2010 Access to Care Data Book,” St. Louis Regional Health Commission, accessed at [www.stlrhc.org/LinkClick.aspx?fileticket=Qi1NUJukLp8%3d&tabid=38](http://www.stlrhc.org/LinkClick.aspx?fileticket=Qi1NUJukLp8%3d&tabid=38) on Aug. 28, 2011.

### THE PROMISING PRACTICE

The Community Referral Coordination Program (CRC) managed by the St. Louis Integrated Health Network (IHN) began in 2007. Its goals are to:

- enhance access to a primary care home and health resources for uninsured/underserved patients
- reduce nonemergent use of EDs
- enhance continuity of care
- strengthen communications/processes among safety-net providers

The mission of the IHN is to improve access, quality and affordability of care by providing a mechanism for the community health centers and hospitals to work together. It has 10 member organizations, including all the community health centers, the St. Louis City and County health departments, the St. Louis University and Washington University Schools of Medicine, and St. Louis Connect Care, which provides outpatient specialty care for the safety-net population. The St. Louis Regional Health Council and the Missouri Primary Care Association are technical advisers to IHN.

Referral coordinators employed by IHN work onsite in participating hospitals with nonemergent ED patients to connect them with a primary care provider for follow-up and preventive care. Coordinators are now working in the EDs of the seven partner hospitals that serve large numbers of uninsured and Medicaid patients.

Most of the referral coordinators are social workers, and they talk with ED patients before they are discharged.

The coordinator:

- provides the patient with education emphasizing the importance of using a primary or urgent care center for nonemergent care
- explains that transportation may be available from the primary care home and assists the patient in setting this up
- assists the patient with primary care home selection based on geographic area, patient preference and availability of appointment times among the primary care health centers
- works with staff at the selected primary care home to schedule an appointment for the patient
- notifies the patient of the appointment
- refers the patient, as needed, to a health coach for additional support in health care management

Referral coordinators have access to the hospital electronic medical records systems. In some hospitals, they can make notes in the patients' charts.

The benefits of referral coordination are being extended to inpatients through a pilot project with SSM St. Mary's Health Center, which began in 2009, and more recently with Barnes-Jewish Hospital. The focus of these pilot projects is to assess the degree to which the CRC reduces readmission rates and ensures community follow-up with primary care providers upon discharge. In particular, the focus is on patients with chronic care needs to increase the utilization of preventive care services available in the community.

Referral coordinators also strive to increase ED providers' awareness of patients' health literacy limitations and needs. They also familiarize patients with the services provided by community health centers.

More detailed information about the CRC Program can be found at [www.stlouisihn.org/initiatives.php](http://www.stlouisihn.org/initiatives.php).

## **THE RESULTS**

More than 1,000 patients were successfully connected to a health center during 2008-2009. The participating hospitals feel the program is working well. Formal evaluation is ongoing, through the use of "Efforts to Outcomes" software that tracks the payer mix of patient referrals and other measures. Another outcome indicator being tracked is the rate of kept appointments at the community health centers. One center saw the percentage of appointments kept by individuals referred by the coordinators almost double, increasing from 19 percent to 35 percent by the end of 2009. It is hoped that this trend will continue.

The ultimate desired outcomes are a decrease in return visits to the ED and readmissions of patients referred through the program. Although the ability to do this type of tracking does not yet exist, a limited regional health information exchange called the Network Master Patient Index is being developed and will begin implementation very soon. This will enable more sophisticated analysis of patient encounters and help to answer these questions.

Data from the CRC Program led to a survey of community health center patients to identify access barriers, which in turn led to the 2009 formation of a Health Center/Hospital Referral Task Force. The task force is charged with providing strategic oversight to the CRC program and community referral processes. This task force continues to study ways to improve connections between hospital EDs and primary care providers, with the ultimate goal of reducing nonemergent use of EDs and no-show rates at health centers.

## **Contact Information**

**Bethany Johnson-Javois**

CEO

St. Louis Integrated Health Network

1520 Market St., Ste. 4034

St. Louis, MO 63103-2625

314/657-1483

[www.stlouisihn.org](http://www.stlouisihn.org)

## [APPENDIX] RESULTS OF LITERATURE SEARCH FOR ARTICLES ON COLLABORATION BETWEEN HOSPITALS AND FQHCs

### 1. Health Serv Res. 2005 Jun;40(3):923-40.

Survival strategies for Michigan's health care safety net providers.

Jacobson PD, Dalton VK, Berson-Grand J, Weisman CS.

University of Michigan School of Public Health 109 Observatory, Ann Arbor, MI 48109-2029, USA.

Comment in

Health Serv Res. 2005 Jun;40(3):941-52.

**OBJECTIVE:** To understand key adaptive strategies considered by health care safety net organizations serving uninsured and underinsured populations in Michigan.

**DATA SOURCES/STUDY SETTING:** Primary data collected through interviews at community-based free clinics, family planning clinics, local public health departments, and Federally Qualified Health Centers from 2002 to 2003.

**RESEARCH DESIGN:** In each of six service areas in Michigan, we conducted a multiple-site case study of the four organizations noted above. We conducted interviews with the administrator, the medical or clinical director, the financial or marketing director, and a member of the board of directors. We interviewed 74 respondents at 20 organizations.

**PRINCIPAL FINDINGS:** Organizations perceive that unmet need is expanding faster than organizational capacity; organizations are unable to keep up with demand. Other threats to survival include a sicker patient population and difficulty in retaining staff (particularly nurses). **Most clinics are adopting explicit business strategies to survive. To maintain financial viability, clinics are: considering or implementing fees; recruiting insured patients; expanding fundraising activities; reducing services; or turning away patients. Collaborative strategies, such as partnerships with hospitals, have been difficult to implement. Clinics are struggling with how to define their mission given the environment and threats to survival.**

**CONCLUSIONS:** Adaptive strategies remain a work in progress, but will not be sufficient to respond to increasing service demands. Increased federal funding, or, ideally, a national health insurance program, may be the only viable option for expanding organizational capacity.

PMCID: PMC1361175

PMID: 15960698 [PubMed - indexed for MEDLINE]

\*\*Short section outlining potential relationships with hospitals, mostly focuses on challenges.

### 2. ED Manag. 2009 Sep;21(9):97-9.

Systems ponder placing federally qualified clinics within EDs of hospitals.

[No authors listed]

**A plan being considered to put Federally Qualified Health Centers (FQHCs) inside of hospital EDs might be put into effect in the Detroit area, according to the plan's sponsor.** Such a move could create challenges for ED managers. Seek the assistance of the FQHC staff in handling triage. Review all EMTALA requirements that might apply to such an arrangement. Make sure that the new billing arrangements are in compliance with federal regulations.

PMID: 19739483 [PubMed - indexed for MEDLINE]

3. Trustee. 2003 Oct;56(9):8-14, 1.

Meshing missions.

Larson L.

**Hospitals and Federally Qualified Health Centers (FQHCs) have a lot to offer each other. From diverting non-emergency ED visits to allowing hospitals to divest themselves of unprofitable primary care services, it is a partnership worth exploring.**

PMID: 14596050 [PubMed - indexed for MEDLINE]

\*\*this article includes a couple of case studies describing collaborative relationships between FQHCs and hospitals

4. Acad Med. 2001 Nov;76(11):1159-64.

Collaboration between an internal medicine residency program and a federally qualified health center: Norwalk Hospital and the Norwalk Community Health Center.

Mazur EM, Cleary JP, Pols KB, Neligan P, Karish DO, Breen T, Nurick PE.

Department of Medicine, Norwalk Hospital, CT 06856, USA.

*Eric.Mazur@NorwalkHealth.org*

In 1999, Norwalk Hospital and an independent, community-based board collaboratively developed the Norwalk Community Health Center (the NCHC). The objectives of the affiliation were to (1) create a new, free-standing, high-quality community health center, (2) optimize grant and clinical revenue, (3) create an ideal venue for ambulatory care training for residents, and (4) replace the traditional and increasingly inefficient hospital-based primary care clinics. **The hospital transferred all of its primary care clinical activity to the new community health center and provides an ongoing financial subsidy of the NCHC operations via a forgivable loan. In exchange, the NCHC granted Norwalk Hospital 24% of the seats on its board of directors and purchases all primary care provider services from the hospital. For adult medicine, the contract providers are exclusively Norwalk Hospital internal medicine residents and faculty.** Contract charges are based not upon actual staffing but upon a standard formula relating full-time-equivalent providers to patient visits. The new 10,000 square-foot NCHC contains 2,500 square feet of additional integrated space, rented from the NCHC by Norwalk Hospital, which supports the residency education program. The NCHC opened in April 1999 and received FQHC status in November 1999. Adult medicine volume increased 30%, from 36.8 daily visits in the old hospital-based clinics to 48.0 at the NCHC. Resident and patient satisfaction are high. The NCHC now receives cost-based visit reimbursement from Medicaid and has received \$1.8 million in state, federal, and local grants.

PMID: 11704522 [PubMed - indexed for MEDLINE]

5. J Health Care Poor Underserved. 2011;22(1):311-9.

Creating an effective and efficient publicly sponsored health care delivery system.

Zweifler J, Prado K, Metchnikoff C.

UCSF Fresno Department of Family and Community Medicine, Fresno, CA 93701, USA.

*jzweifler@fresno.ucsf.edu*

An effective and efficient publicly sponsored health care delivery system can increase access to care, improve health care outcomes, and reduce spending. **A publicly sponsored health care delivery system**

**can be created by integrating services that are already federally subsidized: community health centers (CHCs), public and safety-net hospitals, and residency training programs.** The Patient Protection and Affordable Care Act includes measures that support primary care generally and CHCs in particular. **A publicly sponsored health care delivery system combining primary care based in CHCs with safety-net hospitals and the specialists that serve them could also benefit from incentives in the Patient Protection and Affordable Care Act for the creation of accountable care organizations, and reimbursement based on quality and cost control.**

PMID: 21317524 [PubMed - indexed for MEDLINE]

6. Health Aff (Millwood). 2011 Feb;30(2):237-45.

Transforming a traditional safety net into a coordinated care system: lessons from healthy San Francisco.

Katz MH, Brigham TM.

Health Services for County of Los Angeles, CA, USA. [mkatz@dhs.lacounty.gov](mailto:mkatz@dhs.lacounty.gov)

**Since 2007, San Francisco, California, has transformed its traditional safety-net health care “system”-in reality, an amalgam of a public hospital, private nonprofit hospitals, public and private clinics, and community health centers-into a comprehensive health care program called Healthy San Francisco.** The experience offers lessons in how other local safety-net systems can prepare for profound changes under health reform. By July 2010, 53,546 adults had enrolled (70-89 percent of uninsured adults in San Francisco), and satisfaction is high (94 percent). Unnecessary emergency department visits were less common among enrollees (7.9 percent) than among Medicaid managed care recipients (15 percent). **These findings indicate that other safety-net systems would do well to invest in information technology, establish primary care homes, increase coordination of care, and improve customer service as provisions of the national health care reform law phase in.**

PMID: 21289344 [PubMed - in process]

7. J Rural Health. 2008 Winter;24(1):24-31.

Enhancing the care continuum in rural areas: survey of community health center-rural hospital collaborations.

Samuels ME, Xirasagar S, Elder KT, Probst JC.

Department of Family and Community Medicine, and Office of Health Research and Development, College of Medicine, University of Kentucky, Lexington, KY 40536-0284, USA. [samuels@uky.edu](mailto:samuels@uky.edu)

CONTEXT: Community Health Centers (CHCs) and Critical Access Hospitals (CAHs) play a significant role in providing health services for rural residents across the United States.

PURPOSE: The overall goal of this study was to identify the CAHs that have collaborations with CHCs, as well as to recognize the content of the collaborations and the barriers and facilitators to collaborations.

METHODS: The target population was CAHs within 60 miles of CHCs. Surveys were mailed to 386 chief executive officers of CAHs in 41 states who met the study criteria. The response rate was 40.9%. A descriptive analysis using chi-square tests compared the status of partnerships along with factors identified as barriers and facilitators to collaboration.

FINDINGS: Out of the 161 CAH respondents, 24 (14.9%) reported having a collaborative agreement with a CHC, and 2 indicated that they planned to develop a collaborative agreement. A common reason given for not collaborating was lack of awareness of a CHC within the service area. Other barriers identified were competition with CHCs and organizational differences. External funding to start a collaborating service was the most frequently cited factor to facilitate collaborations.

**CONCLUSIONS: The findings indicate that collaborations between CAHs and CHCs are a largely untapped resource. The rural health care services continuum may benefit from increased collaborations.**

PMID: 18257867 [PubMed - indexed for MEDLINE]

8. Issue Brief Cent Stud Health Syst Change. 2008 May;(120):1-7.

Safety net hospital emergency departments: creating safety valves for non-urgent care.

Felland LE, Hurley RE, Kemper NM.

Hospital emergency departments (EDs) are caring for more patients, including those with non-urgent needs that could be treated in alternative, more cost-effective settings, such as a clinic or physician's office. According to findings from the Center for Studying Health System Change's 2007 site visits to 12 nationally representative metropolitan communities, many emergency departments at safety net hospitals--the public and not-for-profit hospitals that serve large proportions of low-income, uninsured and Medicaid patients--are attempting to meet patients' non-urgent needs more efficiently. **Safety net EDs are working to redirect non-urgent patients to their hospitals' outpatient clinics or to community health centers and clinics, with varied results. Efforts to develop additional primary, specialty and dental care in community settings, along with promoting the use of these providers, could stem the use of emergency departments for non-urgent care, while increasing access to care, enhancing quality and containing costs.**

PMID: 18478670 [PubMed - indexed for MEDLINE]

Available at <http://hschange.org/CONTENT/983/#ib3>

9. Res Briefs. 2009 Jul;(13):1-12.

Suburban poverty and the health care safety net.

Felland LE, Lauer JR, Cunningham PJ.

Although suburban poverty has increased in the past decade, the availability of health care services for low-income and uninsured people in the suburbs has not kept pace. According to a new study by the Center for Studying Health System Change (HSC) of five communities--Boston, Cleveland, Indianapolis, Miami and Seattle--low-income people living in suburban areas face significant challenges accessing care because of inadequate transportation, language barriers and lack of awareness of health care options. Low-income people often rely on suburban hospital emergency departments (EDs) and urban safety net hospitals and health centers. Some urban providers are feeling the strain of caring for increasing numbers of patients from both the city and the suburbs. Both urban and suburban providers are attempting to redirect patients to more appropriate care near where they live by expanding primary care capacity, improving access to specialists, reducing transportation challenges, and generating revenues to support safety net services. Efforts to improve safety net services in suburban areas are hampered by greater geographic dispersion of the suburban poor and jurisdictional issues in funding safety net services. **To improve the suburban safety net, policy makers may want to consider flexible and targeted approaches to providing care, regional collaboration to share resources, and geographic pockets of need when allocating resources for community health centers and other safety net services and facilities.**

PMID: 19685599 [PubMed - indexed for MEDLINE]

10. J Interprof Care. 2009 Mar;23(2):185-94.

How to know together? Physicians' co-orientation between hospitals and health centres.

Mertala S.

Department of Social Studies, University of Lapland, Rovaniemi, Finland.  
*sirpa.mertala@ulapland.fi*

Not enough attention has been paid to the complex co-operative reality of health care personnel's work. This paper focuses on the interconnection between two health care institutions: public hospitals and communal health centres in Finland. The analysis presented in this article is based on the accounts of physicians working in primary and secondary care. The article discusses how the context is complex from the standpoint of co-operational expertise and what tensions arise when comparing the accounts. The concept of "knowing together" is used in order to express the co-operative orientation of professionals. The paper considers what it means to "know together", and what professionals see as the boundaries and possibilities when asked to consider patient care chains that stretch across organizations.

PMID: 19225973 [PubMed - indexed for MEDLINE]

11. J Ambul Care Manage. 2004 Oct-Dec;27(4):339-47.

The value of collaboration in eliminating barriers to preventive care and screening among underserved populations.

Margolin FS, Hasnain-Wynia R, Torres GW, Pittman MA.

Health Research and Educational Trust, One N Franklin, Chicago, IL 60606, USA.  
*fmargolin@aha.org*

Collaboration among a community's institutions and its residents can help increase the use of appropriate screening, preventive, and primary care services. To improve the health of the community, institutions must reach out to their colleagues and other stakeholders. They must not only deal with the structure of the health-care delivery system but also be responsive to the characteristics of the local population groups they are trying to serve. **Over the last several years, a group of 25 community-based partnerships across the country have used a multifaceted model to guide their work in making their communities healthier. Through a wide variety of initiatives tailored to local needs, they have not only improved people's health but also provided a series of benefits to the partnering organizations and the community as a whole.**

PMID: 15495746 [PubMed - indexed for MEDLINE]

12. A Manual on Effective Collaboration Between Critical Access Hospitals and Federally Qualified Health Centers

U.S. Department of Health and Human Services' Health Resources and Services Administration Office of Rural Health Policy

<http://www.hrsa.gov/ruralhealth/pdf/qhcmmanual042010.pdf>

April 2010

The central point of this manual is to illustrate that through cooperation and collaboration, critical access hospitals and federally qualified health centers, particularly those in close proximity and serving similar communities, can better meet community need, enhance each other's roles, and stabilize and expand needed services. Although directed at FQHCs and CAHs, many insights on collaboration can be applied to small rural hospitals and FQHCs serving similar communities. The manual conveys the importance of these rural health service providers and specific information on the definitions, roles, responsibilities and other key attributes of CAHs and health centers. Those sections show that the number of CAHs and FQHC service sites have grown considerably during the past 10 years, giving them pivotal and evolving roles in rural health delivery systems. The presence of CAHs and FQHCs has been shown to further strengthen rural delivery systems through more appropriate use of health care services, improved patient safety and continuity of care and expanded service availability in rural communities. An understanding of those issues sets the stage for the depiction of collaborative potentials, successes and challenges portrayed in the last two sections, which focus on lessons learned and site specific examples.