



Sharing Resources and Working Together: The Rural Collaborative

Rural Health Value Innovation Profile

March 2026

What: A network of 31 rural public hospitals in Washington formally organized as the Rural Collaborative.

Why: Member hospitals maintain their independence by sharing resources and working together, which allows them to better care for their communities and remain financially viable.

How: The Rural Collaborative focuses on group purchasing for shared services, peer learning and education, operational support, and joint contracting. It serves as an opportunity for members to share best practices, lessons learned, and expertise; exchange ideas, policies, procedures, and processes; and support one another. Fostering a culture of open communication and mutual support has been key to the success of the Rural Collaborative network.

Summary

The Rural Collaborative is a network of 31 rural public hospitals across Washington state. Formed through the merger of two earlier hospital networks, it emphasizes a culture of collaboration and trust. Through 15 active committees and 5 affinity groups, members benefit from shared services, peer learning, operational support, and preferred pricing. Payer contracting is a major focus, with hospitals focusing on administrative simplification and engaging in value-based agreements tailored to their unique demographics and priorities. A subset of members has also formed an Accountable Care Organization (ACO). Looking ahead, the Rural Collaborative is working with Medicaid managed care organizations to reduce claims denials and is planning to launch a request for proposal for a Medicare Advantage plan to work with them on improving operational efficiency and financial outcomes.

Introduction

The Rural Collaborative is a non-profit 501c-3, membership-based network of 31 public rural hospitals located throughout Washington State and supported through member dues, grants and program fees. The Rural Collaborative serves as an opportunity for members to share best practices, lessons learned, and expertise; exchange ideas, policies, procedures, and processes; negotiate the terms and conditions of contracts; and support one another. Culture has been key to the success of the Rural Collaborative as it develops and addresses new and emerging challenges.¹

History and Members

The Rural Collaborative was formed by a small group of rural hospitals on the western side of the State and has since merged with a network on the east side of the State. The Western Washington Rural Health Collaborative, started in 2001 as a network of five rural hospitals located in the western part of the state, primarily focusing on health information technology and related grant opportunities. Over time, the network expanded to additional hospitals, and the network's resources and capacity increased.

The Northwest Rural Health Network was established in 2002 and included 15 hospitals in eastern Washington, focusing on Health Information Technology (HIT) and upgrading electronic health records (EHRs). For more than 5 years, the two networks' regional and cultural differences kept them separate. However, as the rural hospitals gained new leadership, perceived cultural differences declined, and as the scale and capacity of the Western Washington Rural Health Collaborative increased, opportunities slowly emerged, relationships were forged, the networks aligned into one network to support hospitals across the state, and the Rural Collaborative was formally established. On September 15, 2008, the Rural Collaborative was incorporated as a non-profit 501c-3.

“Culture is a key part of the success of the Collaborative. It requires a lot of trust and willingness to engage and learn; that is how they [members] can thrive.” – Jac Davies, Director of Member Programs

Like other small rural hospitals throughout the U.S., Rural Collaborative member hospitals operate as low-volume health systems. Participating hospitals offer a variety of services across the continuum of care: acute care, emergency room, emergency medical services, swing bed, clinics, wellness programs, skilled nursing/long-term care, specialty clinics, behavioral health, oral health, and others.

¹ [The Rural Collaborative 2024 Annual-Report](#)

The Rural Collaborative is unique in that all its 31 members are rural public hospitals. This is a critical distinction that is required for membership because: 1) each rural hospital district is a taxing district with the ability to collect taxes from residents and is responsible for the health and well-being of all the people in its district, and 2) in 1997, the Washington State Legislature established an Interlocal Agreement as part of the Revised Code of Washington (RCW) known as the Interlocal Cooperation Act.² The RCW gives statutory authority for government entities (including hospital districts) to work together and grants public hospital districts statutory protection to collaborate and jointly negotiate payer contracts. The legislation was intended to “foster the development of cooperative and collaborative arrangements among rural public hospital districts by specifically authorizing cooperative agreements and contracts for these entities under the interlocal cooperation act.”³

Network Operations and Priorities

The mission of the Rural Collaborative is, “We defend, create and design the future of rural health care through collective strategy and action.” To advance this mission, the Rural Collaborative offers its members group purchasing, peer learning and education, operational support programs, and joint contracting.

Group Purchasing for Shared Services

The Rural Collaborative’s group purchasing focuses on goods and services that align with members’ needs and priorities. Member hospitals receive preferred pricing and may opt in or out at any time. Examples of contracts in place for joint purchasing include:

- **Direct Care Delivery** — Telemedicine and wound care
- **Information Technology** — Staffing and cybersecurity
- **Revenue Cycle** — Artificial Intelligence, billing and coding
- **Education** — Leadership training, human resources

Peer Learning and Education

Peer learning, education, and decision-making occur primarily through 15 committees that have virtual monthly meetings and an annual in-person event. The committees are supported by Rural Collaborative staff and they can access Rural Collaborative quality data, financial data, and administrative data (e.g., hospital characteristics, volume, service lines) for decision-making and planning. Examples of committees include pharmacy, laboratory, chief nurse executive, human resources, information technology, and chief financial officer. These committees foster peer-to-peer sharing, learning, and support and offer the opportunity to ask questions, share policies and procedures, discuss network priorities and needs, and decide which joint contracts to pursue and when. Complementing the committee structure, the Rural Collaborative also has regular lunch and learn sessions that focus on clinical topics, such as breast cancer screening, annual wellness visits, and depression.

² [Chapter 39.34 RCW: INTERLOCAL COOPERATION ACT](#)

³ Ibid.

Administrative and Operational Support Programs

The Rural Collaborative’s operational support includes programs such as an ethics committee, a quality improvement program, and an accountable care organization (ACO). Members can participate in any of these programs. The ethics committee includes a mix of member hospital leadership, providers, and specialists and network staff. It works on behalf of any member hospital needing an independent review of a case because an internal review could create a conflict of interest. The ethics committee independently offers an ethics review assessment and review of each case on behalf of the member hospital. The quality improvement program allows hospitals to share aggregate data (data with no patient identification) to enhance quality of care, reduce medical errors, and promote health care providers’ adherence to best practices. This is facilitated via the Rural Collaborative’s contract with the Washington Hospital Association to use DASH (a data sharing platform), where hospitals report data on a set of clinical measures.⁴ Additionally, over the past year, the Rural Collaborative started accessing data from the state’s Medicaid Managed Care Organizations (MCO), allowing the Rural Collaborative to see where hospitals collectively stand with specific quality measures (e.g., breast cancer screening). Rural Collaborative hospitals with contracts with the Medicaid MCOs can receive customized reports and dashboards containing aggregate and individual hospital data to inform financial and quality improvement activities.

A subset of eight Rural Collaborative hospitals formed an ACO that participates in the Medicare Shared Savings Program. The current ACO was initially a part of the Physicians of Southwest Washington ACO. The eight Rural Collaborative hospitals established a separate ACO once they met patient volume requirements. Rural Collaborative members not participating in the ACO indicate they have not joined due to cost, program requirements, scale of attributed patient population, and prioritization of other value-based care (VBC) efforts. As of January 2026, none of the other Rural Collaborative members are planning to join the ACO.

“Everyone [network hospitals] wants to do the right thing for their patients but the system is not set up to incentivize this.”

– Elya Prystowsky, Rural Collaborative Executive Director

⁴ [DASH-DASH-Premium-1-pg-Summary.pdf](#)

Payer Contracting

Payer contracting is a top priority for the Rural Collaborative. Through the RCW Interlocal Agreement described above, all Rural Collaborative members are authorized to jointly contract with payers. This is done for the benefit of the providers and the payers, focusing mainly on administrative simplification, contract terms and conditions (e.g., submitting payments, billing, denials). Although payer pricing is transparent, as required by federal payer pricing transparency laws, Rural Collaborative members do not jointly negotiate price or payment amounts for different procedures. For joint contracting purposes, the Rural Collaborative uses the “messenger model” for payer contracts.

The messenger model is used when the Rural Collaborative negotiates payer contracts based on predetermined standards and expectations for its members. Once the payer contracts are ready for signature, they are distributed to each hospital, and each hospital executive independently decides whether to sign the contract. To operationalize the messenger model, the Rural Collaborative has a senior director of payer contracting and work groups consisting of member financial leadership, consultants, as well as others as needed. Each work group is dedicated to one payer contract for a period of 3-6 months, working on a contract typically impacting 8 – 22 hospitals. Therefore, most member hospitals are engaged in the payer contracting process, relying on and trusting one another to get the work completed. Once the work group has a contract ready for review, it is shared with member hospitals for their review and determination of next steps. As of December 2025, the Rural Collaborative had 10 payer contracts in place, in process, or being reviewed. The State Office of the Insurance Commissioner, the state agency responsible for regulating the state’s insurance industry, is authorized to determine when a health insurance company contract requires renegotiation. Because services vary across hospitals, contracts may include hospital-specific components. If a member hospital has a specific contract issue unique to them, network experts can be deployed to work on the issue within that hospital’s payer contract.

Key factors for participating hospitals when considering value-based contracts include payer mix, patient population, and individual hospital priorities. For example, hospitals serving a higher percentage of those over the age of 65 may prioritize Medicare arrangements, hospitals serving college towns with a large state employee population may prioritize commercial payers and contracts, and those with younger or migrant populations may prioritize Medicaid contracts. There is also variation in what hospitals consider

“value” in contracts with payers. For example, some hospitals may value quicker access to payment so the hospital can invest in population health that will pay dividends. For other hospitals, value is defined as payer adherence to the contract terms and timely payment.

“It’s hard to implement any of the payment models when they [state and federal government and health plans] keep changing the rules.” – Elya Prystowsky, Rural Collaborative Executive Director

Future Plans

The Rural Collaborative has partnered with four Medicaid MCOs to reduce the administrative burden of denied claims for long-term member viability. Through this partnership, the Rural Collaborative is analyzing claims data from the Medicaid MCOs and hospitals, identifying opportunities for improvement including many revenue cycle issues stemming from hospital-side errors. The Rural Collaborative has also identified that Medicare Advantage plans deny claims 14 times more often than Traditional Medicare, and the value of those denied claims is 1.5 times higher than denied claims from Traditional Medicare. As a result, staff time pursuing payments increased significantly, often ending without reimbursement. To tackle this, the Rural Collaborative plans to issue a request for proposal (RFP) for a Medicare Advantage Plan willing to collaborate “in a new way”. The goal is to maintain access to care through enhanced operational efficiency and reduced claim denials.

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For more information about the Rural Health Value project, contact:
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