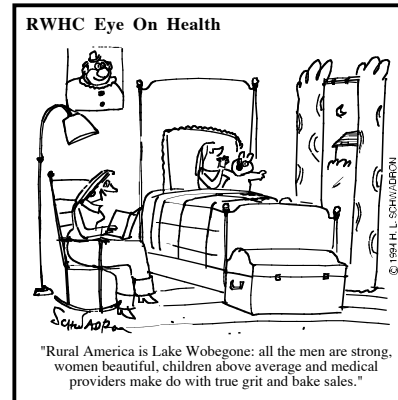




Rural Can Lead Through Individual and Community Care Collaboration



Tim Size, Executive Director
Rural Wisconsin Health Cooperative
18th Annual NW Regional Rural Health Conference
Spokane, Washington, March 25th, 2005

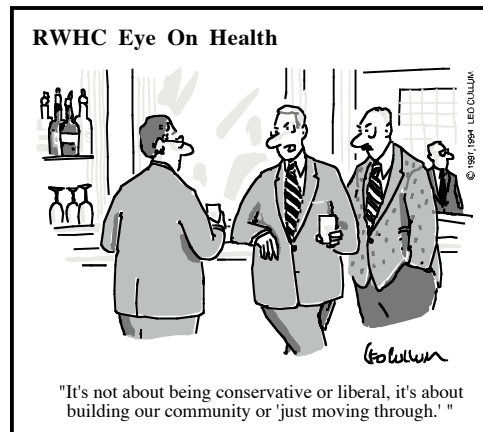
Talk Outline

- This Isn't New
- So Why Now?
- Couple Case Histories
- Barriers
- Is Your Organization Ready?
- First Steps?
- The Risk Of Doing Nothing
- The Bottom Line
- Some Resources

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Rural Has Long Understood Individual-Community Link



"The healthcare system of the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should **balance and integrate needs for personal healthcare with broader community-wide initiatives that target the entire population.**"

Fostering Rapid Advances In Healthcare: Learning From System Demonstrations,
The Institute of Medicine of the National Academies of Science, 2002.

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This Isn't New

Three early national community health initiatives: The Community Care Network Demonstration Program, ACT National Outcomes Network, and the Coalition for Healthier Cities and Communities merged into The Association for Community Health Improvement, a program of the Health Research and Educational Trust, an American Hospital Association affiliate with a focus on:

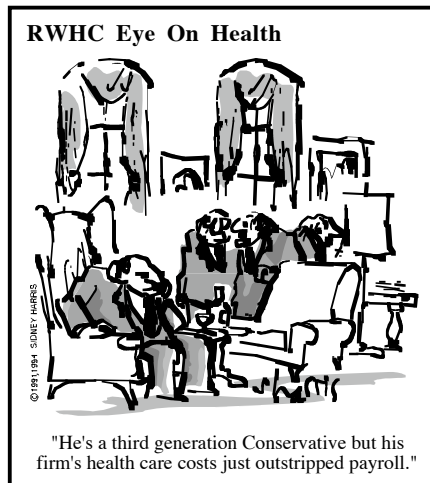
- ♦ **"health care delivery and preventive health systems that ensure accessibility and are accountable to local needs**
- ♦ **careful planning for and measurement of progress toward defined community health goals, and;**
- ♦ **broad community engagement in resolving systemic challenges to community health and social well-being."**

Association for Community Health Improvement <http://www.communityhlth.org/>

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New Era Driven By Unsustainable Cost Trend



- Increased overall health care costs leading to concern re provider charges and their transparency
- Increased number of uninsured leading to law suits re collection & billing practices
- Increased overall scrutiny leading to concern re community benefit & not for profit status.

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Federal Health & Human Services Rural Task Force

"The strong relationship between adequate income, sufficient food, strong social networks, and good health necessitates coordination among various health care and social service agencies..."

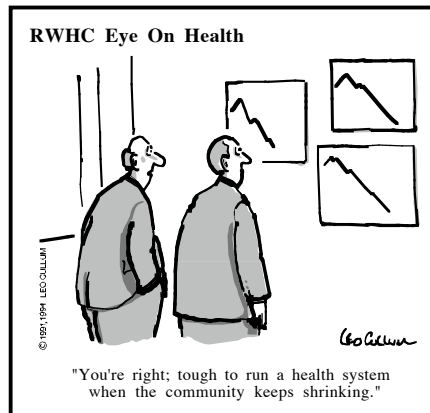
"In many rural communities, service providers often make alliances with one another and exhibit extraordinary resourcefulness and resilience."

HHS Rural Task Force. One department serving rural America. Report to the Secretary; July 2002. Available at <http://ruralhealth.hrsa.gov/PublicReport.htm>

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Rural Health & Community Development Linked At Hip



- Rural development must become a major state policy goal, associated with agri. policy, not secondary to it.
- State rural development policy must be cross-sectoral and cross-jurisdictional.
- Communities must (1) foster new economic engines, (2) be change agents and (3) support entrepreneurs, public & private.
- Rural health leadership must join other community leadership to make it happen.

Toward a Place-Based Rural Policy Keith Mueller, Director, RUPRI
Center for Rural Health Policy Analysis, 6/03

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National Advisory on Rural Health and Human Services

“Collaboration is a means to a broad-based goal: healthy rural communities... The IOM’s Committee on the Future of Rural Health Care applied the IOM’s six healthcare “Aims” (safety, effectiveness, patient centered, timeliness, efficiency& equity) to the broader goal of community well-being.”

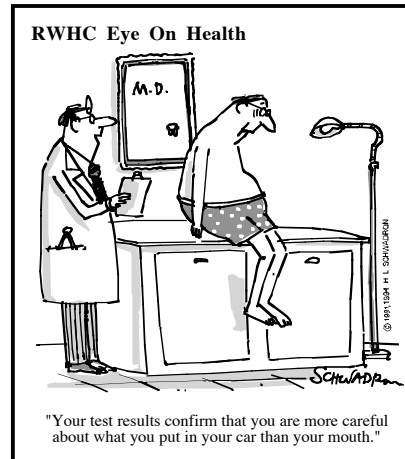
“In doing so, the IOM recognized the importance of an inclusive approach that reaches beyond traditional health care delivery.”

Final Draft of the *2005 Report to the Secretary* by the National Advisory
Committee on Rural Health and Human Services, 12/20/04.

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IOM Committee on the Future of Rural Health



"Rural communities must reorient their quality improvement strategies from an exclusively patient- and provider-centric approach to one that also addresses the problems and needs of rural communities and populations."

Committee on the Future of Rural Health Care. Quality through collaboration: the future of rural health care. Washington, DC: National Academies Press; 2004.

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Quality Aim	Personal Health	Population Health
Safety	Reduce medication errors.	Reduce auto accidents.
Effectiveness	Use best practices to care for diabetic patients.	Public school policies reduce risk obesity/diabetes.
Individual-Centered	Improve provider & patient communication.	Regional networks respect community preferences.
Timeliness	Appointments available within reasonable limits.	Epidemics and other threats to community as whole identified earlier than later.
Efficiency	Investing in electronic health records as a means to more efficient care.	Public reporting of population-based measures of health status.
Equity	Treat all patients with equal respect.	Public policies that encourage appropriate distribution of providers.



IOM Rural Report: Recommendation #1

“Congress should provide the appropriate authority and resources to the Department of Health and Human Services to support comprehensive health system reform demonstrations in five rural communities.”

“These demonstrations should evaluate alternative models for achieving greater integration of personal and population health services and innovative approaches to the financing and delivery of health services, with the goal of meeting the six quality aims of the *Quality Chasm* report.”

“The Agency for Healthcare Research and Quality (AHRQ), working collaboratively with the Health Resources and Services Administration (HRSA), should ensure that the lessons learned from these demonstrations are disseminated to other communities, both urban and rural.”

Committee on the Future of Rural Health Care. Quality through collaboration: the future of rural health care. Washington, DC: National Academies Press; 2004.

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IOM 2004 Rural Report: Key Finding #1

“A wide range of interventions are available to improve health and health care in rural America, but priorities for implementation are not yet clear. HRSA is the obvious agency to take the lead in setting priorities, in collaboration with other federal agencies, such as AHRQ and the Centers for Disease Control and Prevention, as well as with rural stakeholders.”

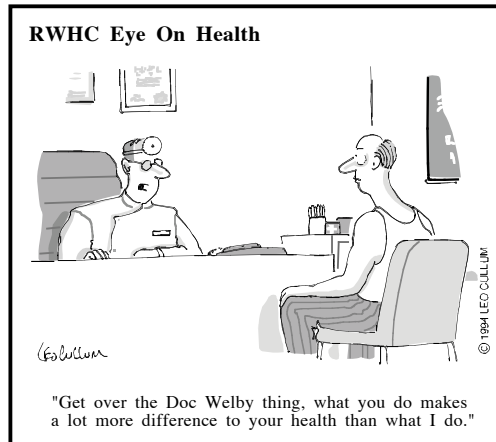
“This would entail systematically cataloguing and evaluating the potential interventions to improve health care quality and population health in rural communities.”

Committee on the Future of Rural Health Care. Quality through collaboration: the future of rural health care. Washington, DC: National Academies Press; 2004.

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IOM Rural Report: Key Finding #2



"Rural communities engaged in health system redesign would likely benefit from leadership training programs. Such training programs could be provided by AHRQ and the Office of Rural Health Policy working collaboratively with private- and public-sector organizations involved in leadership development..."

Committee on the Future of Rural Health Care. Quality through collaboration: the future of rural health care. Washington, DC: National Academies Press; 2004.

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Example #1: Health Network Improves Local Schools

- Franklin Community Health Network (FCHN) is composed of Franklin Memorial Hospital and 3 affiliates in Farmington, ME.
- A major focus for FCHN activities involves targeted investment to strengthen community infrastructure.
- Reductions in revenue for Farmington schools were undermining the quality of education, the hospital's recruitment and retention of healthcare professionals, and the region's economy.
- FCHN with other key community leaders waged a successful campaign resulted in legislation to reformulate property tax allocations and increased annual funding for the rural schools in FCHN's service area by \$1.3 million.

"Beyond the Medical Model: Hospital's Improve Health Through Community Building" *CCN Briefings*, Fall, 2001.

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Example #2: Cardiologist Acts To Reduce Demand

- A Marshfield, Wisconsin cardiologist recognized he was seeing too much preventable heart disease due to obesity.
- He recognized obesity as a community problem that needed community solutions.
- “Healthy Lifestyles” was launched in 2001 with \$100,000 budget.
- The school system was an early partner in the community collaboration, believing that the best starting point in the community was with children.
- Private businesses in the community were among the next organizations to participate, with one firm mapping out a one-mile walking path on its grounds for use by a walking club.”
- Medical leadership was necessary but not sufficient.

* Final Draft of the 2005 Report to the Secretary by the National Advisory Committee on Rural Health and Human Services, 12/20/04.

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Strategic Barriers to Providers Getting Involved

- **Tradition.** With some notable exceptions, the role of providers has been seen as treating individual patients. Concern about the population as a whole has been “the job” of local and state public health departments.
- **Resources.** Hospitals and clinics that are struggling to address traditional responsibilities with tight budgets are not looking for new roles “that no one will pay us to do.”
- **Values.** The third is the conflict or discomfort that most of us feel when talking about addressing population health issues, many of which relate to individual behaviors – other people’s choices and their freedom to make those choices.

Unpublished manuscript: “Population Health Improvement & Rural Hospital Balanced Scorecards: A Conversation,” Tim Size, David Kindig & Clint MacKinney

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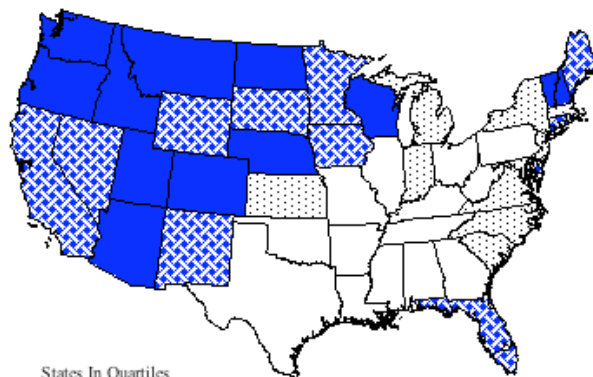
Technical Barriers to Providers Getting Involved

- Technical barriers are narrower in scope. Most metrics found to be useful for strategic planning and Balanced Scorecards are measured on a monthly or quarterly frequency. Consequently, results of interventions aimed at moving the data can be tracked and used to test intervention effectiveness, identify unintended consequences, and motivate change.
- In contrast, traditional population health metrics, such as the Wisconsin County Health Rankings:
(<http://www.pophealth.wisc.edu/wphi/research/reportcards.htm>), are available annually at best, and typically represent a geographic area that doesn't align with a hospital service area.

Unpublished manuscript: "Population Health Improvement & Rural Hospital Balanced Scorecards: A Conversation," Tim Size, David Kindig & Clint MacKinney

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Discharges for Ambulatory Care Sensitive Conditions
per 1,000 Medicare Enrollees (2001)



States In Quartiles

35 - 63

64 - 74

75 - 85

86 - 116

Data: Dartmouth Atlas, "2001_med_discharges_state.xls"
Graph: RWHC, 4/27/04

"ACSCs"

A Major
Measure of
Community
Health That
Is Largely
Ignored

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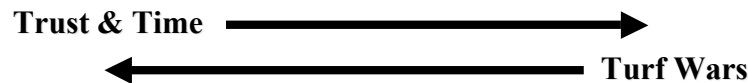
**Selected AHRQ Prevention Quality Indicator Rates (PQI)
For Discharges from Any Wisconsin Hospital between 10/1/00 to 9/30/03
For ZipCodes in RWHC Member Hospital Service Areas (HSA)*
Age Adjusted**

Dartmouth HSA*	Bacterial Pneumonia Rate/ 100K Population	Percent of WISC Rate	Congestive Heart Failure Rate/ 100K Population	Percent of WISC Rate
LOW	224	71%	252	63%
WISC	317	100%	398	100%
RWHC	353	111%	397	100%
HIGH	599	189%	593	149%

* An HSA is a cluster of zipcodes named by the town or city where the greatest proportion (plurality) of residents in each zipcode were hospitalized.
These rates are not gender adjusted; they do not reflect out of state hospitalizations.

RWHC:TS:8/30/04

How Far Are You Ready To Go?



Network →	Coordinate →	Cooperate →	Collaborate
Exchange Information	Exchange Information AND Harmonize Activities	Exchange Information AND Harmonize Activities AND Share Resources	Exchange Information AND Harmonize Activities AND Share Resources AND Enhance Partner's Capacity

The Collaboration Primer by Gretchen Williams Torres and Frances Margolin

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Ready or Not? A Checklist for Successful Collaborating

- | | |
|--|---|
| <ul style="list-style-type: none"><input type="checkbox"/> Host organization ready?<input type="checkbox"/> The right partners involved?<input type="checkbox"/> Shared vision unifies partners?<input type="checkbox"/> Partners aware what is expected?<input type="checkbox"/> Partners know partnership goals and objectives?<input type="checkbox"/> People to do the work have been identified, staffed and made accountable?<input type="checkbox"/> “Best practices have been researched and shared?<input type="checkbox"/> Assets residing within the partnership have been mapped? | <ul style="list-style-type: none"><input type="checkbox"/> Partnership encourages participation in and sustainability of its work?<input type="checkbox"/> Partnership actively recruits new members?<input type="checkbox"/> Defined governance model?<input type="checkbox"/> Leadership is effective?<input type="checkbox"/> Communication/outreach plan?<input type="checkbox"/> Financial needs known and addressed?<input type="checkbox"/> Work evaluated/revised?<input type="checkbox"/> Partnership knows challenges that it faces? |
|--|---|

The Collaboration Primer by Gretchen Williams Torres and Frances Margolin

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Some Next Steps: National

- Recommendations of *Quality Through Collaboration* (previous;y noted).
- Recommendations on Community Collaboration in soon to be released 2005 Report to the Secretary from the National Advisory Committee on Rural Health & Human Services*:
 - ♦ Create a Web resource page for “models that work,” successful collaborations in rural places.
 - ♦ Support research that will further specify opportunities and barriers.
 - ♦ Support leadership development for rural community organizations and residents.
 - ♦ Require grant recipients engaged in direct delivery of services to demonstrate an effect on community development.

* Final Draft of the *2005 Report to the Secretary* by the National Advisory Committee on Rural Health and Human Services, 12/20/04.

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Some Next Steps: Regional

- Advocate for improved population health measurement techniques and increased population health improvement valuation.
- Assist hospitals and clinics, and other stakeholders, to begin to link the mission of community health improvement to budget, operations, and performance measurement.
- Partner with academic institutions to design research projects that test hypotheses related to provider performance improvement and population health measurement.

Unpublished manuscript: “Population Health Improvement & Rural Hospital Balanced Scorecards: A Conversation,” Tim Size, David Kindig & Clint MacKinney

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Some Next Steps: Local

- Devote a periodic Board meeting or a portion of every Board meeting to review available population health indicators.
- Add Board members with specific interest and/or expertise in population health measurement and improvement.
- Create a “population health” subcommittee of the Board to explore opportunities for partnerships with other community organizations to improve proactively population health.
- Consider hospital or clinic employees or employees of a proactive local employer as a “community” and develop interventions to improve employee health. Then, expand the experience to the larger community.

Unpublished manuscript: “Population Health Improvement & Rural Hospital Balanced Scorecards: A Conversation,” Tim Size, David Kindig & Clint MacKinney

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The Risk Of Doing Nothing

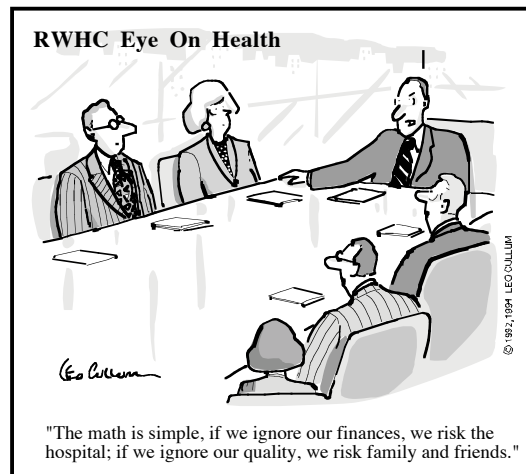
"A few years ago, the most frequently cited example of a sector's failure to adapt to changing times was the railroads; falling from tycoon status in the late 19th century to bankruptcy in the 20th. The railroads kept on doing what initially had been a successful business strategy – selling access to rail cars and track. However, the railroads failed to adapt to a market that was redefining transportation as cars and airplanes, not trains."

"In a similar fashion, **healthcare "markets" are being redefined; shifting from purchasing service units to purchasing quality outcomes. Importantly, quality care is increasingly defined in both personal and population perspectives.** This developing redefinition of healthcare needs to be reflected in rural provider strategic planning. It is a great opportunity for rural health."

Unpublished manuscript: "Population Health Improvement & Rural Hospital Balanced Scorecards: A Conversation," Tim Size, David Kindig & Clint MacKinney

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The Bottom Line



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Partial List Of Resources

- **Association for Community Health Improvement**
<http://www.communityhlth.org/>
- ***The Collaboration Primer: Proven Strategies, Considerations and Tools to Get You Started***
<http://www.hret.org/programs/content/colpri.pdf>
- **The Community Tool Box** at <http://ctb.ku.edu/>
- **VHA Health Foundation**
<http://www.vhahealthfoundation.org/vhahf/resources.asp>
- **Kellogg Leadership for Community Change**
<http://www.klccleadership.org/>

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