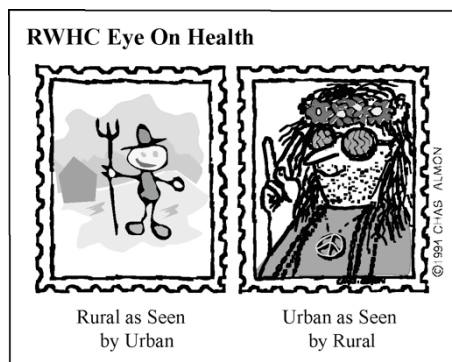




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“A Personal View of Rural Health Leadership: It’s All About Collaboration & Advocacy”
Tim Size to Rural Voices Leadership & Policy Meeting, Washington DC, 3/30/09

A Personal View of Rural Health Leadership: It’s All About Collaboration & Advocacy



Tim Size
Executive Director
Rural Wisconsin
Health Cooperative

Rural Voices Leadership
& Policy Meeting
Washington DC
3/30 – 4/1/09



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Outline of Presentation

1. Presenter’s Perspective
2. Rural Advocacy Often Deals With Myths
3. Why Collaboration & Advocacy Needed?
4. Community Collaboration Not New
5. Why Aren’t We Doing It?
6. Starting or Expanding Collaboration
7. Become a More Active & Effective Advocate
8. Anticipate Barriers to Change



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1. Presenter Perspective

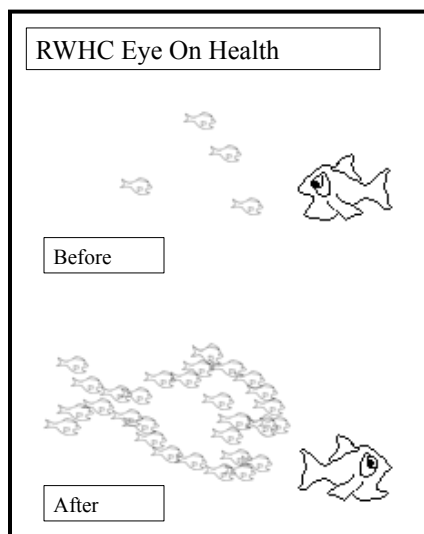


Advocacy at
RWHC is based
on the evidence
but like us all,
we have a set of
experiences and
beliefs that drive
our work.



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Founding Principle: “Strength in Numbers”



First RWHC Cartoon
shortly after being
founded in 1979.



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RWHC Mission & Vision

Mission: Rural WI communities will be the healthiest in America.

Vision: RWHC is a strong and innovative cooperative of diversified rural hospitals; it is (1) the “rural advocate of choice” for its members and (2) develops & manages a variety of products and services.

Specifics re services available at <http://www.RWHC.com>



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RWHC by the Numbers

- Founded 1979
- Non-profit coop owned by 35 rural hospitals (net rev \approx \$3/4B; \approx 2K hospital & LTC beds)
- \approx \$7M RWHC budget (\approx 70% member fees, 20% fees from others, 5% dues, 5% grants)
- 6 PPS & 29 CAH; 24 freestanding; 11 system owned or affiliated



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RWHC Collaborative Services

- Advocacy (Market, Government)
- CAHPS Hospital Survey (AHRQ)
- Clinical: Audiology, Speech, PT
- Coding Consulting Service
- Compliance (Medicare)
- Credentials Verification (NCQA)
- EHR Shared Platform & Support
- Financial Consulting Service
- H2H Learning from Each Other
- Health Careers Web Template
- Health Plan Insurer Contracting
- IT Services, Wide Area Network
- Legal Services
- Peer Review Service
- Professional & Staff Roundtables
- Quality Indicators (JCAHO)
- Recruitment (Nursing/Allied)
- Reimbursement Credentialing



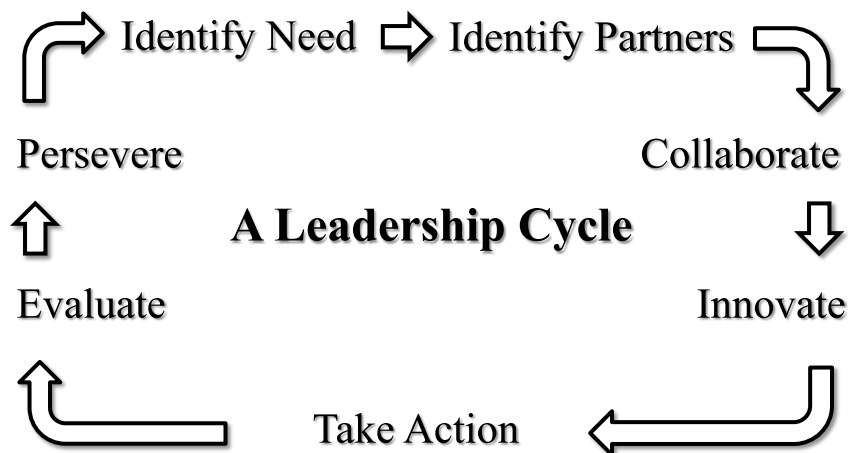
RWHC Current Advocacy Priorities

- Mitigate Work Force Shortages & Maldistribution
- Promote Fair Federal & State Payments & Policies
- Broaden Focus from Healthcare to Community Health
- Fight Exclusionary Market Practices
- Keep Local Care Local
- Support Fair Quality/Price Transparency
- Resist Inappropriate Regulation of Hospitals





Collaboration & Advocacy Use Similar Skills



Above “leadership Cycle” is a variation of the traditional PDSA (plan, do, study, act).



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Rural Advocates Work in Private & Public Sectors



- Rural Health exists in and is driven by both private and public sector beliefs, behaviors and policies.
- Focus is on taking action for a desired future.



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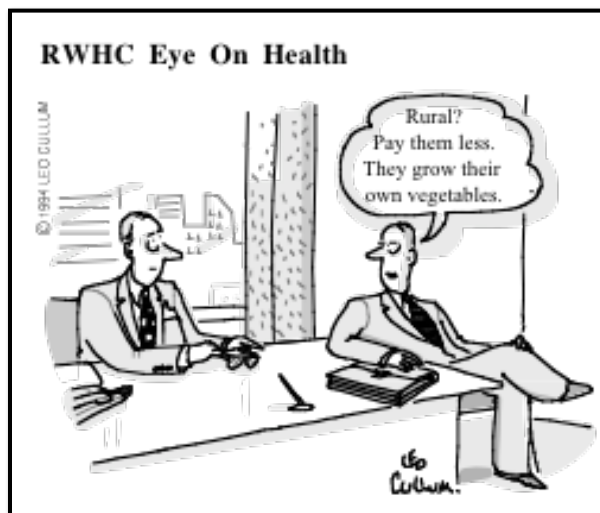
Rural Advocacy Needs to Be 24/7

Rural advocates have an ongoing challenge:

- Public and private sector policy nationally, and even in our states, can be ill informed about or not attend to rural health.
- We must not become complacent; all of us must become more skilled and more active.



2. Rural Advocacy Frequently Deals With Myths





Myths that Mislead Public & Private Policy

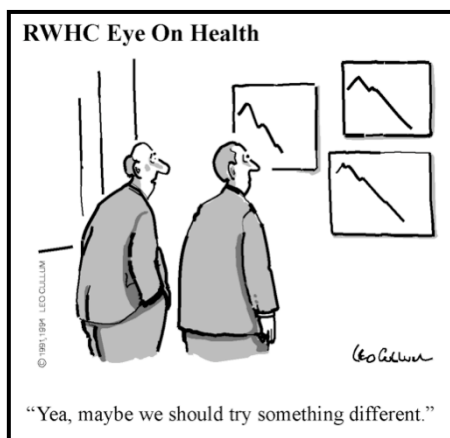
- Rural is west (TX, NC, PA, OH, MI, NY top rural pop.)
- Rural Americans are naturally more healthy
- Rural economy is mostly about agriculture
- Rural health care should cost less than urban care
- Rural health care is inordinately expensive
- Rural health care is lower quality; bigger/urban is better
- Rural hospitals are just band-aide stations
- Rural hospitals & clinics are poorly managed/governed
- Rural residents don’t want to get care locally

* U.S. 2000 Census, Non-Metro Population By State



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3. Why Collaboration & Advocacy Needed?



American Hospital Association’s “Health for Life,
Better Health, Better Health Care” August, 2007

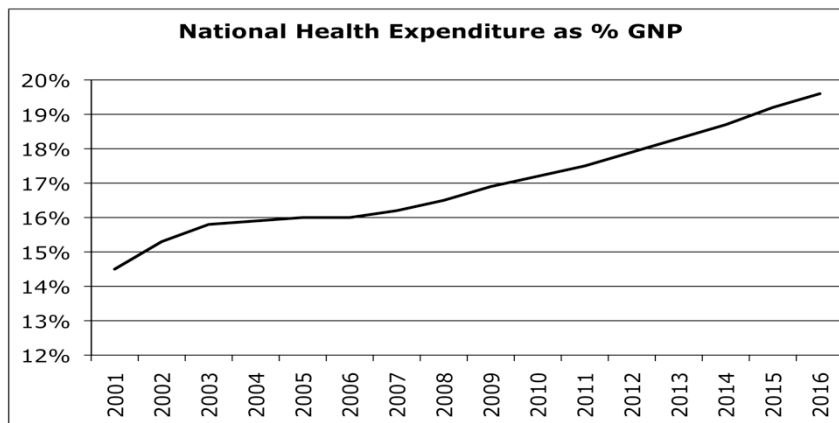
“We must help all reach
highest potential for
health and reverse the
trend of avoidable
illness. Individuals must
achieve healthier
lifestyles; take
responsibility for health
behaviors and choices...
and act.”



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Spending Trend Is Widely Seen As Unsustainable

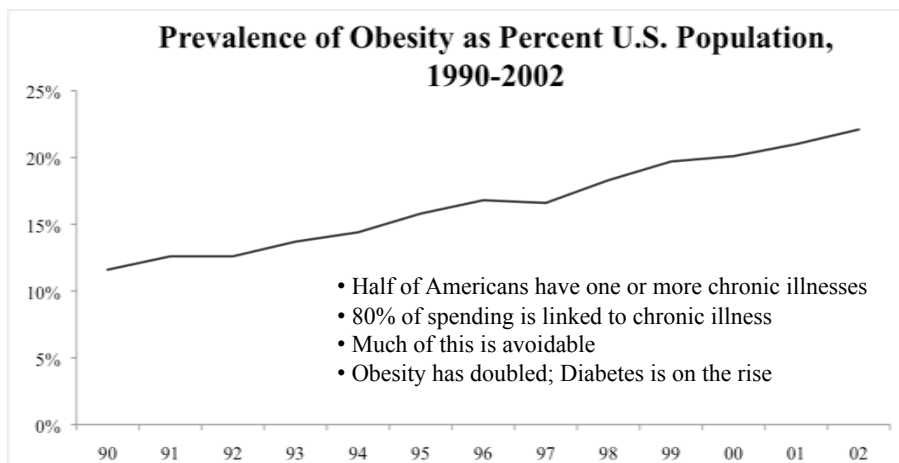


Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/>



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A Sicker Chronic Illness On The Rise



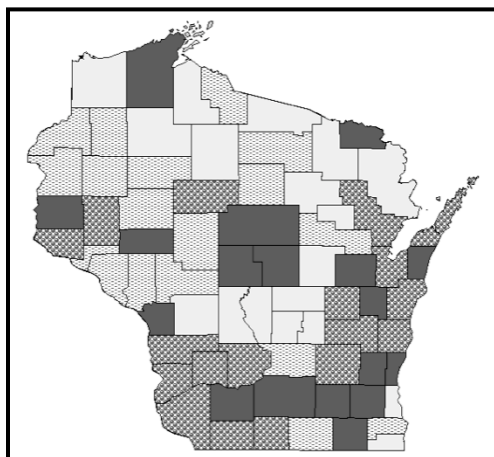
American Hospital Association, "Health for Lie, Better Health, Better Health Care" 2008 Data: Centers for Disease Control and Prevention.



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Health Status in Wisconsin Counties



Worst Quartile (white)
Second Quartile (red)
Third Quartile (redder)
Best Quartile (reddest)

75% urban counties
better than average
compared to 33% of
rural counties better
than average.

Above calculated from the 2007 “*Wisconsin County Health Rankings*,”
UW Population Health Institute



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Healthy Rural Communities More Than Health Care

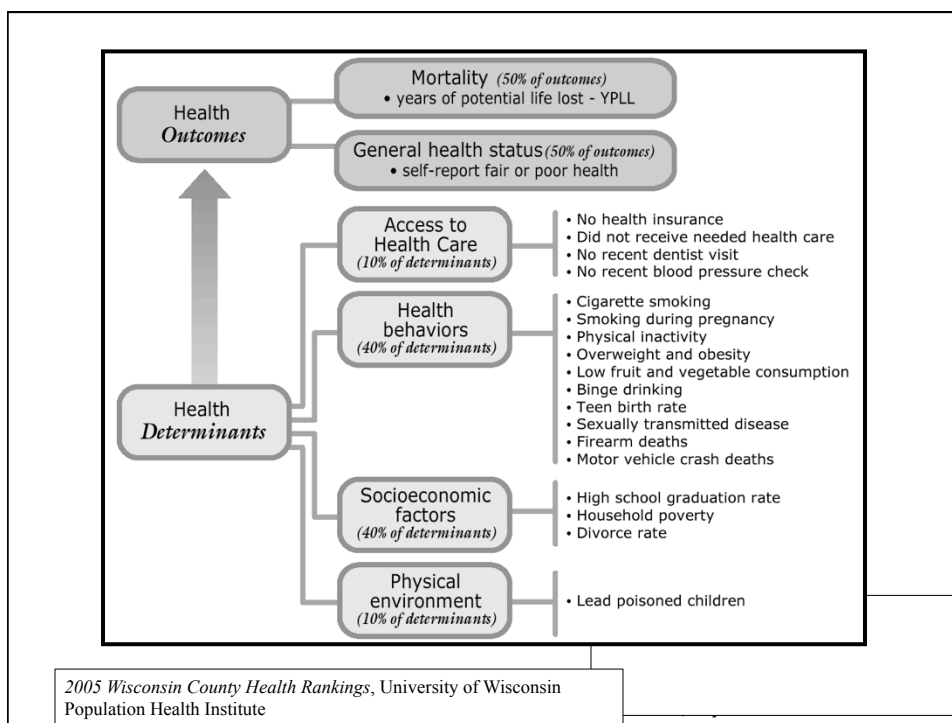
Rural counties in Wisconsin are predicted to have worse health status and they do because individual behaviors like smoking and exercising matter, as do education, jobs and income.

These factor influence individual and community health as much or more than access to quality health care.

Above calculated from the 2007 “*Wisconsin County Health Rankings*,”
University of Wisconsin Population Health Institute



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Critical Link of Community & Economic Health

“Businesses will move to where healthcare coverage is less expensive, or they will cut back and even terminate coverage for their employees. Either way, it's the residents of your towns and cities that lose out.”

Thomas Donohue, President & CEO, U.S. Chamber of Commerce

“If we can change lifestyles, it will have more impact on cutting costs than anything else we can do.”

Larry Rambo, CEO, Humana Wisconsin and Michigan



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Rural Jobs Need New Rural Health Strategy

- Business community & public policymakers essential components for healthy communities. *Benjamin*
- Need to go beyond history of governmental public health and private practitioner animosity to achieve benefits of public-private partnership. *McGinnis*
- Key link between worker health, productivity and economic benefit. *Simon & Fielding*

Health Affairs, July/August, 2006



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Community Health a Rural Opportunity (1 of 2)

We See . . .

- Advances are being made both in outcomes measurement as well as in understanding health determinants.
- More attention is being paid to the value questions of what we get for what we invest.

But . . .

- Little policy time/money devoted to these issues
- No public or private entity has accountability for over all community health outcomes

“What Would You Do If ‘Pay For (Population Health) Performance’ Came To Your Community?,” David Kindig MD, PhD, University of Wisconsin at NRHA in Reno on 5/17/06



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Community Health a Rural Opportunity (2 of 2)

And . . .

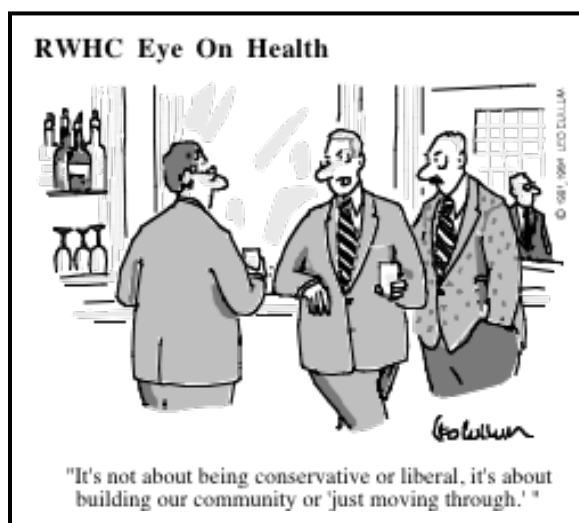
- Managerial and financial structures which have as their goal community health outcome improvement are primitive and need significant attention in the near future
- Rural communities have opportunities for national leadership on this issue

“What Would You Do If ‘Pay For (Population Health) Performance’ Came To Your Community?,” David Kindig MD, PhD,
University of Wisconsin at NRHA in Reno on 5/17/06



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4. Healthy Community Collaborations Not New



But now
there is a fair
amount of
evidence it is
moving from
a third tier to
a first tier
focus.



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It Has Been Around for Decades in Background

Association for Community Health Improvement, a program of AHA’s Health Research and Education Trust, has long focused on:

- health care delivery and preventive health systems to ensure accessibility and are accountable to local needs
- careful planning for and measurement of progress toward defined community health goals, and;
- broad community engagement to resolve systemic challenges to community health

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



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2002 - Federal DHHS 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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2004 - IOM Committee on 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.”

“A wide range of interventions are available to improve health in rural America, but priorities for implementation are not yet clear.”

“... catalogue and evaluate 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; 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. |



2007 - Traditional Providers & Public Health?

The National Steering Committee on Hospitals and the Public's Health, convened by Health Research and Education Trust, recommends that:

“hospitals engage in community-based collaboration bridging gaps in the public health care system. The report also emphasizes the need for innovation and collaboration between hospitals and other private and public health care organizations in order to expand access to care, reduce health disparities and prevent chronic disease.”

The National Steering Committee on Hospitals and the Public's Health
<http://www.hret.org/hret/programs/nschph.html>



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“Hospitals & Public’s Health” Recommendations

1. Eliminate health disparities
2. Coordinate care
3. Promote primary prevention
4. Optimize access to care for all
5. Advocate payment for prevention
6. Build the community’s capacity to stay healthy
7. Support recreating the public health infrastructure and
8. Expanding capacity

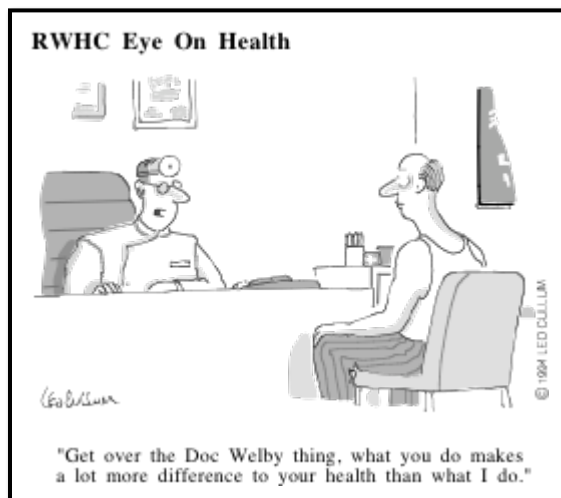
The National Steering Committee on Hospitals and the Public's Health
<http://www.hret.org/hret/programs/nschph.html>



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5. Why Aren’t We Doing It?



Because we follow \$\$\$ incentives and mostly think of health coming from providers who fix us when broken.



Strategic Barriers to Providers Getting Involved

- **Tradition.** the role of providers has been seen as treating individuals. Population health seen as the job of local and state public health departments.
- **Resources.** Hospitals and clinics struggling to address traditional responsibilities are not looking for roles “that no one will pay us to do.”
- **Values.** The discomfort that many of us feel when talking about population health issues, that relate to individual behaviors – other people’s choices and “rights” to make those choices.

“Population Health Improvement & Rural Hospital Balanced Scorecards,”
Tim Size, David Kindig & Clint MacKinney, *Journal Rural Health*, Spring, 2006





6. Starting or Expanding Collaboration

RWHC Eye On Health



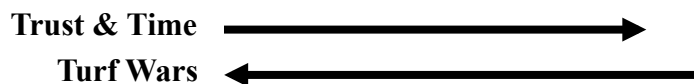
“This wellness stuff probably comes from the same people who never had fun in high school; I’ll start wellness after the first heart attack.”

Collaboration isn’t easy; it takes more time; if the “cost” outweighs the benefit, do it on your own, keep it simple.



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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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A Checklist for Successful Collaborating

- | | |
|----------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Host organization ready? | <input type="checkbox"/> Partnership encourages participation in and sustainability of its work? |
| <input type="checkbox"/> The right partners involved? | <input type="checkbox"/> Partnership actively recruits new members? |
| <input type="checkbox"/> Shared vision unifies partners? | <input type="checkbox"/> Defined governance model? |
| <input type="checkbox"/> Partners aware what is expected? | <input type="checkbox"/> Leadership is effective? |
| <input type="checkbox"/> Partners know partnership goals and objectives? | <input type="checkbox"/> Communication/outreach plan? |
| <input type="checkbox"/> People to do the work have been identified, staffed and made accountable? | <input type="checkbox"/> Financial needs known and addressed? |
| <input type="checkbox"/> “Best practices have been researched and shared?” | <input type="checkbox"/> Work evaluated/revised? |
| <input type="checkbox"/> Assets residing within the partnership have been mapped? | <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: State

- 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 around provider performance improvement and population health measurement.

“Population Health Improvement & Rural Hospital Balanced Scorecards,”
Tim Size, David Kindig & Clint MacKinney, *Journal Rural Health*, Spring, 2006



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Some Next Steps: Local Community

- Devote a periodic Board meeting or a portion of every Board meeting to review available population health indicators.
- Add Board members with specific interest in population health measurement and improvement.
- Create a “population health” subcommittee of the Board to seek community partnerships.
- Consider employees as a “community” and develop interventions to improve employee health. Then, expand the experience to the larger community.

“Population Health Improvement & Rural Hospital Balanced Scorecards,”
Tim Size, David Kindig & Clint MacKinney, *Journal Rural Health*, Spring, 2006



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Tip #1: Partnership Grants Must Be “Authentic”

1. Good grants are good “business” plans.
2. They start with an idea about which there is passion and that you all would do with your own organizations money, if you it.
3. There needs to be a clear “public purpose” for the requested use of public/foundation funds.
4. If successful, real value added—justifying the funder’s investment and reviewers time.
5. Bold/Innovative is good and characteristic of funded grant. But reviewers as a whole can be conservative.



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Tip #2: Not Every Group Is a Partnership

1. A partnership has a written agreement that defines its purpose, member roles and responsibilities.
2. A partnership works according to an explicit strategic plan that includes accountability.
3. A partnership is not owned/controlled by one entity.



Tip #3: It’s About Social Entrepreneurship

1. Network development is an entrepreneurial activity and as such success is not certain.
2. The odds can be increased if all participants understand that networks are businesses, albeit typically “non-profit.”
3. A key responsibility is to NOT become a small business startup that fails after running through its initial capital (aka grant).
4. Sustainability is too often thought of as just one of those annoying questions one has to answer at the end of the applications about “life after the grant.”





Tip #4: Communication is Core Competency



RWHC Meeting Guidelines from Tercon, Inc.

- Everyone Participates, No One Person Dominates
- Listen As An Ally–Work To Understand Before Evaluating
- An Individual’s Silence Will Be Interpreted As Agreement
- Assume Positive Intent First When Things Go Wrong
- Minimize Interruptions And Side Conversations



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Tip #5: Strategy is Both Art & Science

Strategy is both the art and science of employing the political, economic and psychological forces of a group to afford the maximum support to adopted policies.”



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Tip #6: Balanced Portfolio of Services/Advocacy

| | | Value Added | |
|------|---|-------------|-------|
| | | L | H |
| Risk | L | L - L | L - H |
| | H | L - H | H - H |

Green: “Low Risk - High Value Added” Do it!

Red: “High Risk - Low Value Added” Non-starter.

Yellow: “Low Risk - Low Value Added” helpful in short run; “High Risk - High Value Added” provides real value over the long run.



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Tip #7: Seeking the Win-Win is Necessary



*Anne Woodbury, Chief Health Advocate for Newt Gingrich's
Center for Health Transformation

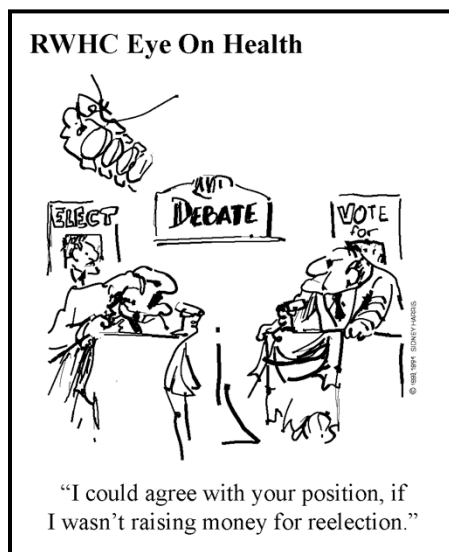
“Say ‘Yes, if ...’
rather than
‘No, because...’ ”



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7. Become a More Active & Effective Advocate



What Drives Advocacy?

- Need to Correct Bias – Critical Access Hospitals
- Opportunity to Reframe – Binge Drinking
- Short-term Fix Possible – Provider Payments
- Broad Coalition Possible – Workforce Data
- Address Core Need – Physician Supply
- Anticipate Problems – Medicare Managed Care
- Can't Be Avoided – Healthcare Costs
- Long-term Significance – Healthier Communities





Your Advocacy Behaviors Matter

- Be Brief
- Be Accurate - NEVER false or misleading info
- Personalize Your Message - cite examples
- Be Prepared - know your issue
- Be Aware Every Issue Has At Least Two Sides - there are stakeholders on the other side
- Be Courteous/Don’t Threaten
- Be Patient - long process; be in for long haul

Wisconsin Hospital Associations Grass Roots Handbook



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Three Prong Advocacy Strategy

Make your best case: Develop concise, credible, persuasive, fiscally responsible, but emotive arguments.

Make friends and form alliances: Find Congressional champions, develop agency contacts, form alliances with a diverse set of groups.

Make it happen: Use some or all of your advocacy tools – government relations, grassroots and media advocacy – based on your level of engagement.

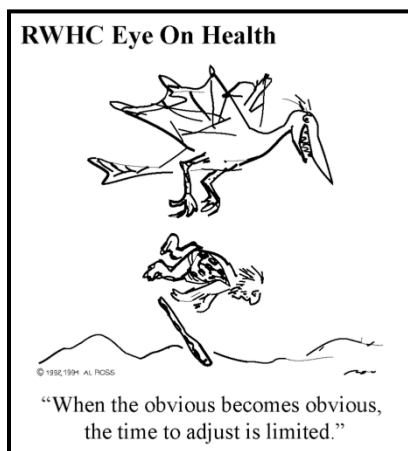
Jennifer Friedman, VP Government Affairs and Policy
National Rural Health Association



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8. Anticipate Barriers to Change



Examples of Barriers to Change (1 of 2)

- Constituencies Often Trump “Good Sense”
- Hope of Gain Must Exceed Fear of Loss
- Trends You See Must Be Made Real
- Impact on Personal Incomes Matter
- Sometimes Agencies Have Own Agenda
- Collective Denial Trumps Raw Numbers
- Never Underestimate Prevalence of Biases
- “Analysis” May Be Obvious, Action Harder





Examples of Barriers to Change (2 of 2)

- Important to Share “Ownership” of Problem
- Stated & Underlying Intent May Differ
- Politics Reflects Our Conflicting Values
- Tradition Conceals Important Questions
- Reasons Policymakers May Stay Uninformed
- Change Tougher if Ignore Cultural Norms
- Challenge to Move Dollars “Upstream”
- Shooting Messenger Sometimes 1st Response



Partial List Of Resources

- **Association for Community Health Improvement** <http://www.communityhlth.org/>
- ***What Counts as Community Benefit? At*** <http://www.chausa.org/>
- **(1) *National Steering Committee on Hospitals and the Public's Health* & (2) *Where Do We Go from Here? The Hospital Leader's Role in Community Engagement*** at <http://www.hret.org/>
- ***The Collaboration Primer: Proven Strategies, Considerations and Tools to Get You Started*** at <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/>





For more info about RWHC go to to **www.rwhc.com**

For the free RWHC *Eye on Health* e-newsletter, email
office@rwhc.com with “subscribe” on subject line.

Rural Assistance Center at **www.raconline.org/** is an
incredible federally supported information resource.

The **Health Workforce Information Center** is RAC’s
new “sister,” a comprehensive online library re health
workforce programs, funding, data, research & policy
<http://www.healthworkforceinfo.org/>

