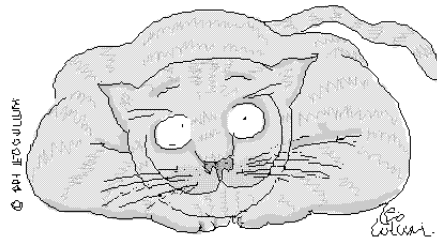


The Art & Science of Rural Health Network Development

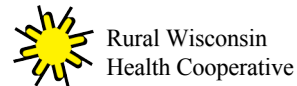
RWHC Eye On Health



A mouse is OK but nothing like a rural
health network to make a good hairball.

Tim Size
RWHC Executive Director

HRSA Rural Health
Network Planning Grantees
Washington, D.C.
August 9th, 2006



Presentation Outline

- I. RWHC Overview as Context for Remarks
- II. Personal Beliefs/Experience about Networks
- III. Communication as a Core Competency
- IV. How Networks Create & Maintain Value
- V. Next Wave of Rural Network Opportunities
- VI. Summary with Time for Questions





I. RWHC Overview (1 of 3)

RWHC Vision - Our Ideal

- Support/enhance rural health and quality of care
- Strong, innovative and mutually supportive network
- Combined strengths meet local health needs

RWHC Mission - Our Approach

- Member owned and operated
- State and national advocacy for rural health
- Clinical & management products and services
- Collaborative managed care & other insurer contracting

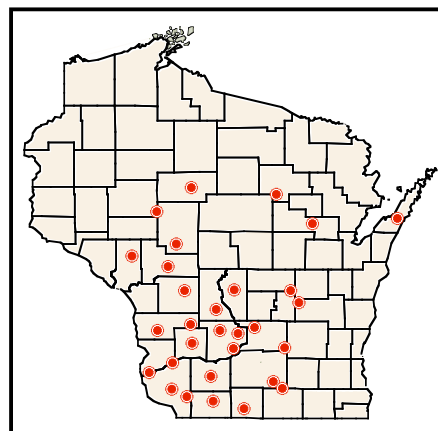
RWHC Strategic Plan as of 7/1/06



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RWHC Overview (2 of 3)

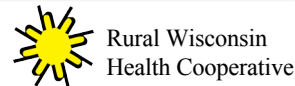
- Non-profit Cooperative owned & operated by 30 rural hospitals (aggregate >\$500 M; 2,000 hospital & nursing home beds)
- >\$4M RWHC budget (70% fees from members, 20% fees from others, 5% dues, 5% grants); excludes significant dollars applied by partners for RWHC members
- 26 are CAHs; 17 independent, 5 outside management and 8 system affiliated



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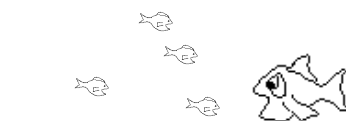
RWHC Overview - Products & Services (3 of 3)

- Advocacy (Market, Government)
- CAHPS Hospital Survey (AHRQ)
- Clinical: Audiology, Speech, PT
- Coding Consulting Service
- Compliance (Medicare)
- Credentials Verification (NCQA)
- Financial Consulting Service
- Grantsmanship
- HMO & PPO Contracting
- IT Services, Wide Area Network
- Legal Services
- Peer Review Service
- Professional & Staff Roundtables
- Quality Indicators (JCAHO)
- Recruitment (Nursing/Allied)
- Reimbursement Credentialing

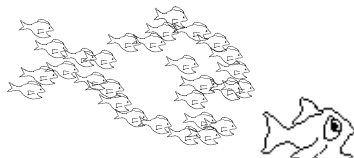


Basic Principle Remains “Strength in Numbers”

RWHC Eye On Health



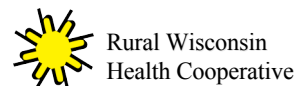
Before



After

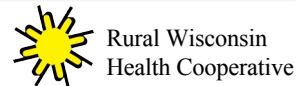
Cartoon #1 from early '80s

All cartoons in this presentation are from the RWHC monthly newsletter and most, with many others, are available for free at www.rwhc.com



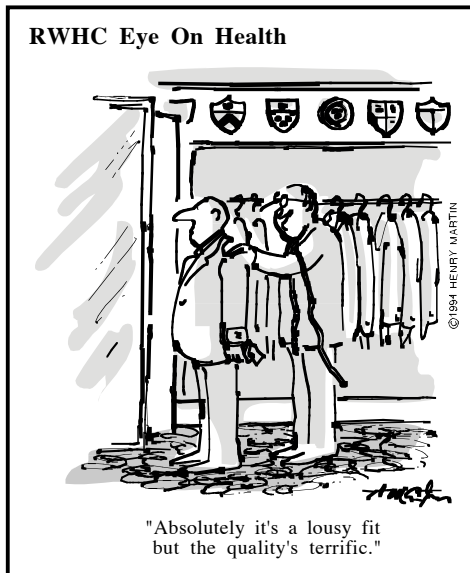
II. Belief #1: Not Every Group Is a Network

- A network has a written agreement that defines its purpose, member roles and responsibilities.
- A network works according to an explicit strategic plan that includes accountability.
- A network is not owned/dominated by one entity.

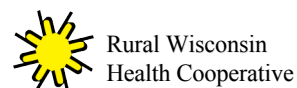


Belief #2: Like Politics, All Networking Is Local

RWHC Eye On Health



- Depends on local history, purpose and context
- Who is and isn't perceived as having "power" is a key local variable.
- Within a community or among communities
- With just one provider type, or cross section of community organizations
- Within health sector or across multiple sectors





Belief #3: It's About Social Entrepreneurship

- Rural networks have attracted significant government, foundation and local investments of time and money.
- Network development is an entrepreneurial activity and as such success is not certain.
- The odds can be increased if all participants understand that networks are businesses, albeit typically “non-profit.”
- A key responsibility is to NOT become a small business startup that fails after running through its initial capital (aka grant). *(This talk is on practices particularly relevant to networks; it is not a primer on business management fundamentals.)*

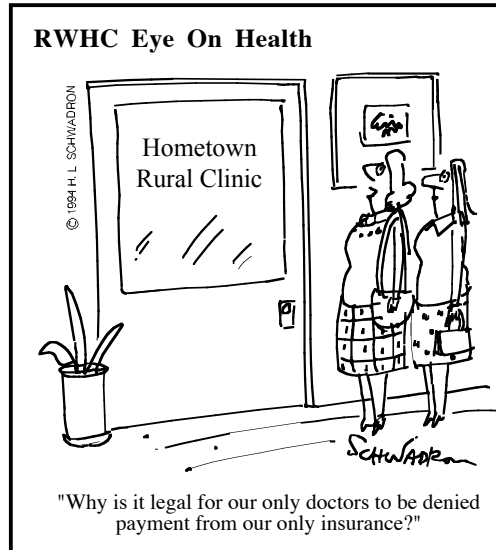


Belief #4: Network Sustainability Starts Yesterday

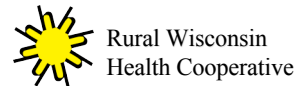
- Networks have many purposes but few can be achieved without a basic level of financial stability.
- If grant funded, sustainability is too often thought of as just one of those annoying questions one has to answer at the end of the applications about “life after the grant.”
- While grants are not paid back like a bank loan, the underlying and tedious detail of good strategic and business planning MUST occur at the beginning.
- All network decisions must include consideration of how the decision helps the network achieve financial stability.



Belief #5: Rural Networks Are Rural Advocates

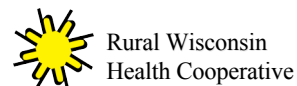


- Rural Health exists in and is driven by both private and public sector beliefs, behaviors and policies.
- Individually and collectively, networks need to be effective in both sectors.



Synergy Between Shared Services & Advocacy

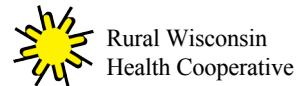
- RWHC begun for shared services, advocacy role accidentally discovered, now key part of mission
- Both enhances external credibility
- Both contribute to operating margin
- Both use same infrastructure
- Both inform each other
- Both help build loyalty & “brand familiarity”



Rural Advocacy: No Shortage of Issues



- Ongoing Rural Myths
- Medicare & Medicaid Funding & Reform
- Workforce Shortages & Maldistribution
- Cost of Care & Insurance
- Quality Accountability & Transparency



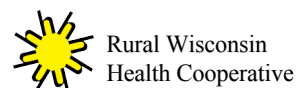
Belief #6: “Network” ≠ “System” (1 of 2)

Network Traits

- Supports Local Autonomy
- Focus On Local Communities
- Strength: Local Credibility
- Tends To Non-Profit Values
- Participation Voluntary

System Traits

- Assumes Local Responsibility
- Focus On Central Issues
- Strength: Capital
- Brings For-Profit Alternatives
- Participation Required





Belief #6: “Network” ≠ “System” (2 of 2)

Network Traits

- Depends On Trust
- Leverage Tertiary Support
- More Health Plan Choices
- Senior Local Leadership
- System Hospitals Active

System Traits

- Less Dependent Upon Trust
- Committed Tertiary Support
- Health Plans—Fewer Choices
- Junior Local Leadership
- Participation More Restricted



Belief #7: Leaders Made Not Born (1 of 4)

- Midwifing, bringing, a vision into reality is at the heart of leadership; the complexity of rural health and creating healthy communities requires an expansion in our commitment and ability to develop collaborative leadership.
- Leaders will arrive without the assistance of any of us but deliberative leadership development will foster more effective and diverse leaders.





Belief #7: Leaders Made Not Born(2 of 4)

- Management practices necessary for successful collaboration are not commonly seen in traditional vertically organized institutions.
- Most administrators have had little experience and even less training regarding leadership within the context of multi-sector or multi-organization collaborative models.

“Leadership Development for Rural Health” by Tim Size, North Carolina
Medical Journal. 2006;67(1)



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Belief #7: Leaders Made Not Born(3 of 4)

- The “natural” administrative response will frequently come out of traditions that may be inconsistent with the actions needed to support networking.
- Development of collaborative relationships takes longer than those based on authority—more time on the front end paid off later with less participant resistance.

“Leadership Development for Rural Health” by Tim Size, North Carolina
Medical Journal. 2006;67(1)

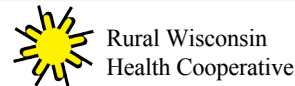


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Belief #7: Leaders Made Not Born(4 of 4)

- We need to focus on leadership development vs. leader development; not just at top, but throughout organizations and communities many people can and do exercise leadership.
- None of us is called to lead on every issue; all are called to interact and support the vision and ideas of others; to have the most effective team.

“Leadership Development for Rural Health” by Tim Size, North Carolina Medical Journal. 2006;67(1)

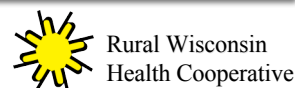


III. Communication as a Core Competency

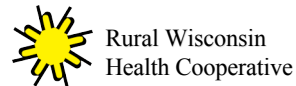
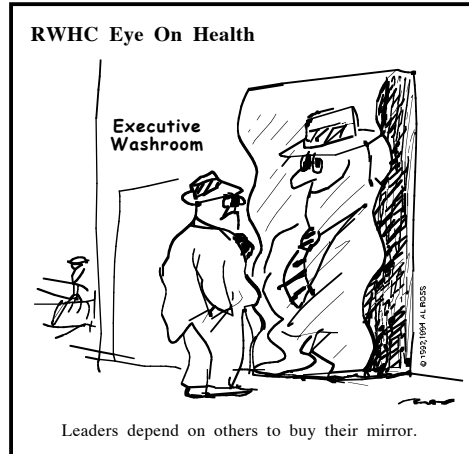


RWHC Meeting Guidelines from Tercon, Inc.



- 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





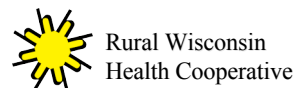
Communicating Starts & Ends With Listening



Develop an Annual Communication Plan

Frequency	Examples		
Annual	Satisfaction & Needs Surveys; E.D 360	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Quarterly	Work Plan & Balance Score Card	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Monthly	Members Open Mike*	<input checked="" type="checkbox"/>	
“ ”	Program/Advocacy Direction Asked*	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
“ ”	Newsletter		<input checked="" type="checkbox"/>
Ongoing	Staff to Staff Phone Email & Phone	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
“ ”	RWHC Web Site		<input checked="" type="checkbox"/>
“ ”	3rd Party Word Of Mouth	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

* = Board Meeting  = Receive Information
 = Give Information





Agenda Explicit, Maintenance & Growth Focused

10:30 am Program & Services Update (Bonnie Laffey) *Enclosure #3*

Enclosed is the monthly update regarding RWHC core services. As appropriate, items will be highlighted, specifically those with participation issues or significant changes.

Opportunity for questions, feedback and direction.

10:40 am Phone Triage Service (Larry Clifford) *Enclosure #5*

Update on phone triage/nurse call center that will provide 24-hour response system for medical/urgent care needs.

Opportunity for questions/discussion/direction.

External Updates Embedded in Board Agenda

- | | |
|---|---|
| <ul style="list-style-type: none">• American Hospital Association• Area Health Education Centers• Bioterrorism Preparedness Advisory Committee• La Crosse Medical Health Science Consortium• National Rural Health Association• WI Academy Rural Medicine• WI eHealth Board | <ul style="list-style-type: none">• WI Hospital Association• WI Health & Educational Facilities Authority• WI Office Rural Health• WI Public Health Council• WI Primary Care Association• WI Rural Health Development Council• WI Select Committee on Health Care Workforce Development |
|---|---|

Above examples from list of over 30 organizations with whom staff and board keep in touch.



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Explicit Staff Accountability to Network Board

RWHC Goals & Objectives	Lead Staff	Status 12/31	Status 3/31	Due Date 05-06	Due Date 06-07	Comments Re Current Year Objectives (Including weight of objectives to be included in the Executive Director's annual review.)
2.2.2. → Sponsor annual awards/events to recognize individual Member employees and increase RWHC visibility.	LC/TS	A	A	6/06	6/07	
2.3. → Grow Existing/New Shared Services						
2.3.1. → Aggressively pursue mid and long term revenue growth opportunities. Intent is to be able to add a senior advocacy position in FY2008-09 paid for by an expanded revenue stream.	TS/LC	A	A	4/06	7/08	[TS:10%] See below objectives as well as Goal #7.
2.3.2. → A needs assessment (including Member satisfaction with current services) completed annually before strategic planning retreat.	LC				3/07	This will allow for earlier input from Member department heads as well as CEOs unable to attend the retreat.
2.3.3. → Comprehensive marketing plan to be developed/implemented for higher profit services (Credentialing, QI & CAHPS).	LC/BL			6/06		Several advertising efforts have been made along with vendor participation at many venues, formal plan needs to be completed.



RWHC Balanced Scorecard Helps Staff Focus

I. Financial/Business

- Profit Margin Variance
- Days in Accounts Receivable
- Non-Member Revenue
- Advocacy Objectives Met

↑ ↑ II. Customer

- Credentialing Satisfaction
- RWHC Roundtable Satisfaction
- Wide Area Network Usage

↑ ↑ III. Internal

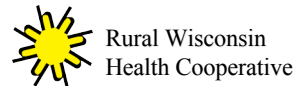
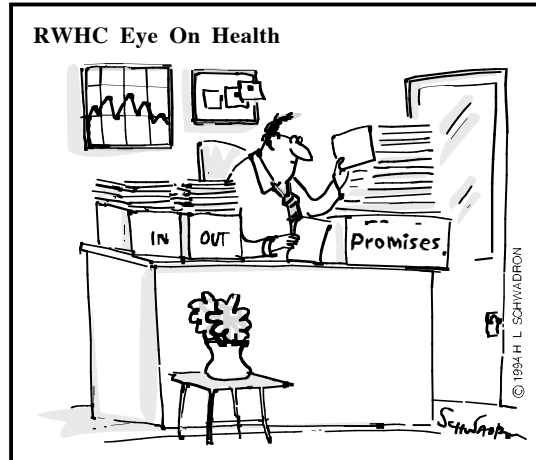
- Member CEO Participation
- Operational Objectives Met

↑ ↑ IV. Investment

- Staff Satisfaction
- Staff Training
- Staff Annual Reviews

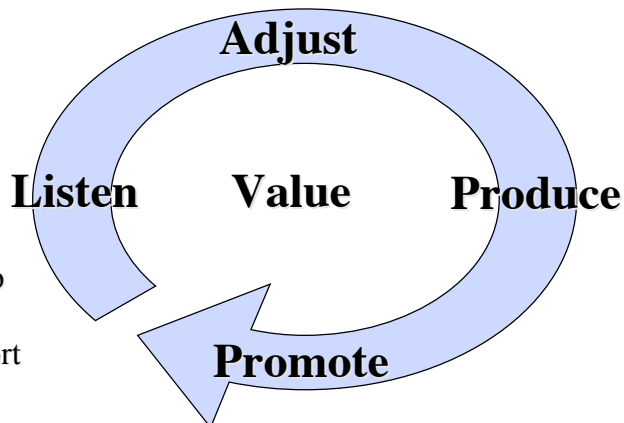


IV. Networks Must Create & Maintain Value

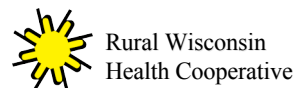


Network Strategy Requires Both Art & Science

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



Above “network growth cycle” is a variation of the traditional PDSA (plan, do, study, act).



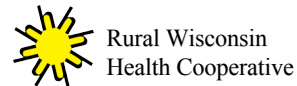
All Networks Need a Mixed Portfolio of Services

		Value Added	
Risk		L, L	L, H
		H, L	H, H

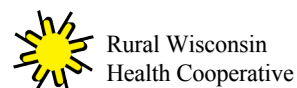
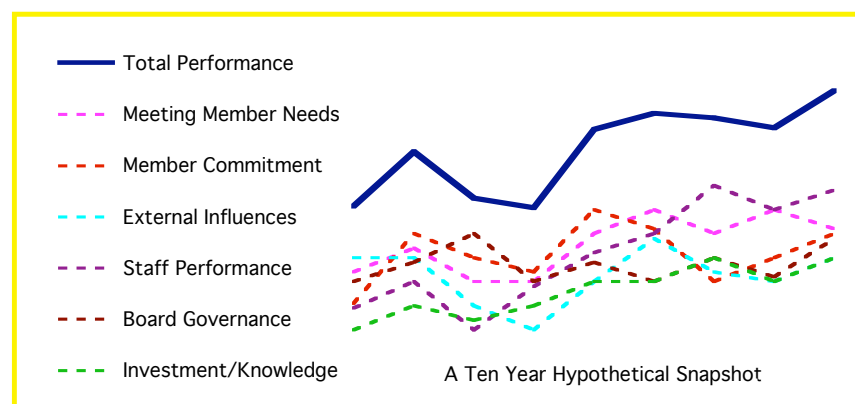
“Low Risk - High Value Added” Obvious to do.

“High Risk - Low Value Added” None starter.

“Low Risk - Low Value Added” maintains interest in short run; **“High Risk - High Value Added”** provides substantive value over the long run.



Multiple Factors Drive Ongoing Reinvention





Principles of Shared Service Development (1 of 2)

1. Network goals frequently satisfied by shared services.
2. They must produce real member benefit.
3. Member and “network” perspectives may differ.
4. They are shaped by the environment (market, technology, member proximity and relationships).

From *Networking For Rural Health* by Anthony Wellever
available at <http://www.ahsrhp.org/ruralhealth/ruralpubs.htm>



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Principles of Shared Service Development (2 of 2)

5. Successful services help to build trust to build service.
6. The decision to offer a service and the decision to use a service are determined by financial & other criteria.
7. More complex services require more complex structures.
8. Shared services increase network cohesion



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Network Services: Basic Planning Questions

- What are key areas which determine network success?
- How attractive is the opportunity?
- What is the payoff for the network, for the members, for the communities?
- What is the timeframe?
- Chances of success?
- What are the risks? Are they acceptable?

From *Networking For Rural Health* by Anthony Wellever
available at <http://www.ahsrhp.org/ruralhealth/ruralpubs.htm>



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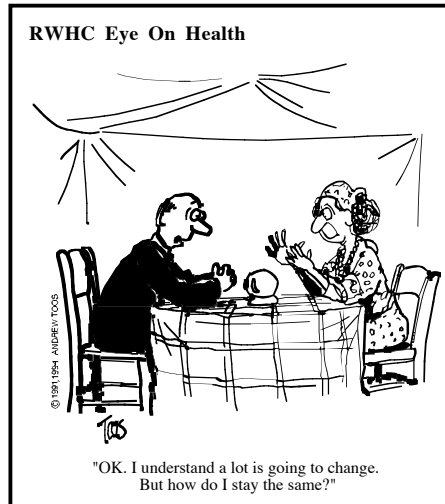
Network Services: More Than 1 Way to Skin Cat

- Contract with a vendor.
- Create and manage a joint venture (include hiring staff) among some or all members to share service.
- Coordinate a shared service that is owned by a member or members.
- Negotiate terms of a master contract with vendors for members to sign bilaterally with vendors.

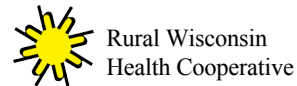


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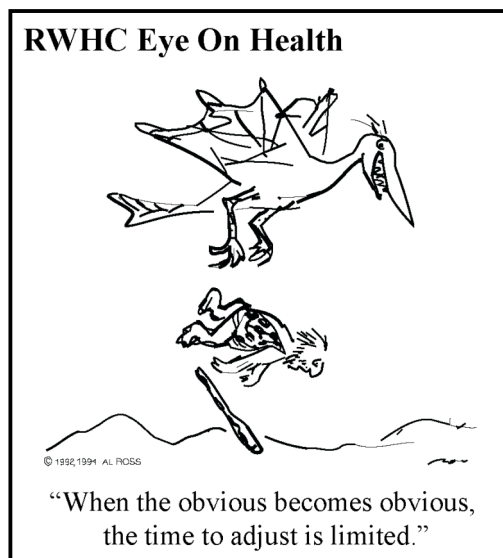
“Say ‘Yes, if ...’ rather than ‘No, because...’ ” *



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



V. Next Wave of Rural Network Opportunities



Collaboration to
effectively bring
Health Information
Technology to rural
communities.

Collaboration by
business, medical
and public health to
improve employee
and community
health status.





HIT Opportunity for Rural Networks (1 of 2)

1. Rural networks can create/share best practices between HIT peers through roundtables and education sessions.
2. By pooling volumes, facilities that work in collaboration can often negotiate better pricing.
3. Through shared HIT staffing, networks can distribute specialized technical expertise among multiple facilities.

Louis Wenzlow, RWHC Director of Health Information Technology



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HIT Opportunity for Rural Networks (2 of 2)

4. Rural networks that engage HIT may have a variety of grant opportunities unavailable to individual facilities.
5. If facilities can agree on specific vendors, significant economies can be created through shared system use.

Louis Wenzlow, RWHC Director of Health Information Technology



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HIT Challenges for Rural Networks

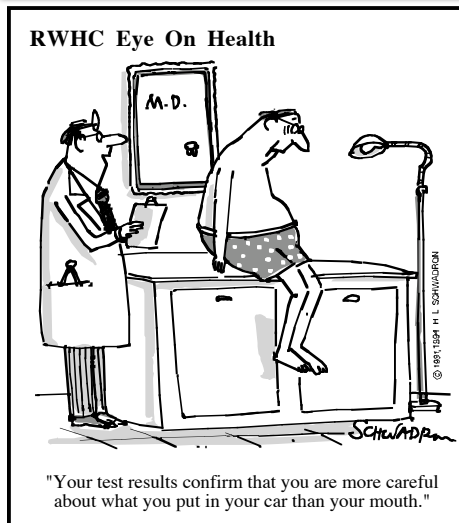
1. Effectively engaging the issue requires significant initial investment in rural-focused HIT expertise.
2. Opportunities for certain types of HIT collaboration depend on organizational needs and financial capabilities coalescing.
3. To achieve the greatest benefits of HIT collaboration, organizations will eventually need to follow certain collaborative standards.

Louis Wenzlow, RWHC Director of Health Information Technology



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Rural Networks Can Improve Population Health



- Access to Health Care (est 10%)
- Health Behaviors (est 40%) e.g. smoking, physical inactivity.
- Socioeconomic factors (est 40%) e.g. education, poverty, divorce rates
- Physical environment (est 10%)

2005 Wisconsin County Health Rankings, University of Wisconsin
Population Health Institute



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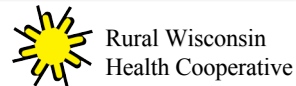
Critical Link of Population & Economic Health

“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.”

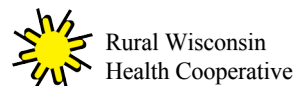
Thomas Donohue President & CEO,
U.S. Chamber of Commerce

“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



Rural Health Needs Strong Public & Private Payers





Initial Local Hospital & Community Steps

- Devote a periodic 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 hospital board to explore opportunities for hospital partnerships with other community organizations
- With local employers, develop interventions to improve employee health; expand experience to the larger community

“Population Health Improvement & Rural Hospital Balanced Scorecards”
by Size T, Kindig D, MacKinney C., *Journal of Rural Health*; 3/06



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Network of Community Networks in Wisconsin

A Strong Rural Communities Initiative has been started in Wisconsin to improve the health of rural communities and reduce healthcare cost inflation by accelerating use of collaboration among medical, public health and business organizations that enhance preventive health services. Includes RWHC, WORH, both Medical Schools and the State’s Rural Health Development Council and six local communities.

RWHC *Eye On Health* Newsletter, 7/06



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VI. SRCI - Appears To Be Right Time/Place

- Sponsored by state's Rural Health Development Council embedded in Wisconsin Department of Commerce
- Acquired \$700K from 3 sources with 4th looking good
- Six local community projects chosen from 22 proposals
- Variety approaches to modifying poor fitness, nutrition habits through wellness programs at work/community
- July/August *Health Affairs* is on “Public Health” and has multiple authors calling for this expanded type of collaboration and the research and policies to support it.



VI. Summary: Networks Are Built on Relationships

1. Make Yourself a Partner Who Can Be Trusted
2. Respect the Need to Effect One's Own Future
3. Involve All in the Planning Process from the Start
4. Assure All Participants Know They Are Needed
5. Share Your Big Picture
6. Agree on Methods of Accountability Up Front
7. Assure that a Fair System of Arbitration is Available
8. Participation Must Makes Sense





Communication Is a Core Network Competency



- Collaboration is as traditional as competition or going it alone.
- Most of us have less experience & training with cooperation.
- We learn best by doing it.



Questions/Discussion?

For a free subscription RWHC newsletter, email office@rwhc.com with "subscribe" on subject line.

RWHC's JCAHO accredited Quality Indicators Program serves 100+ rural hospitals and now also offering CAHPS Hospital Surveys. Info available at: <http://www.rwhc.com/services/services.aspx>

A copy of this handout is available online at: <http://rwhc.com/new.html>

