Health Networks of the Future (Doing More, Better, for Less)

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Outline of Remarks

- RWHC* - One Model of a Hospital Network
- Ongoing Myths Lead to Poor Rural Models
- Tension Between Power of Place & Capital
- Competencies We Need to Develop
- Examples of Hospital-Community Networks
- Advocacy Needed as a Core Competence
- The Rural and Community Advantage

*RWHC: Rural Wisconsin Health Cooperative

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; RWHC

(1) is the "rural advocate of choice" for its members and

(2) develops & manages a variety of products and services for members and non-member.

Information on RWHC services available at ***http://www.RWHC.com***

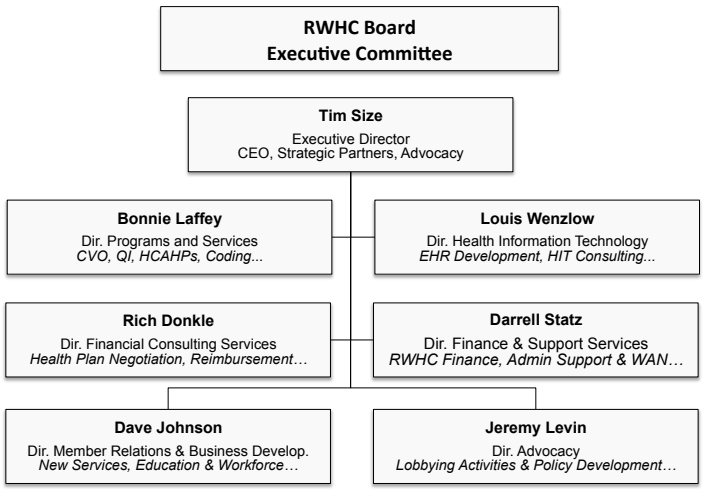
RWHC by the Numbers

- Founded 1979.
- Non-profit coop owned by 34 rural hospitals (who have net rev ≈ $3/4B; ≈ 2K hospital & LTC beds).
- ≈ $8M RWHC budget (≈ 80% member sales/ dues; 15% other sales, 5% grants).
- 7 PPS & 27 CAH; 20 freestanding; 14 system affiliated.

RWHC Composite of Four Models

RWHC Advocacy/Shared Services	RWHC Network Health Plan Contacting
RWHC ITN Shared EHR	RWHC PHO Medicare Contracting

RWHC Leadership Structure



RWHC Shared Services

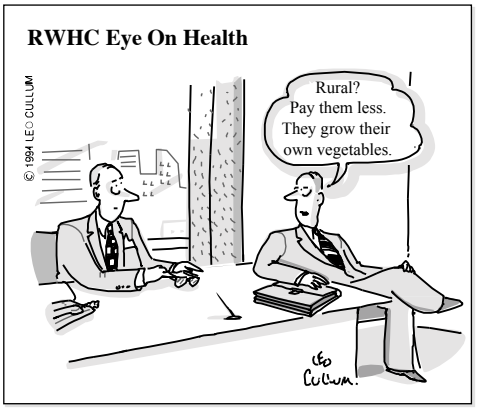
- Advocacy (Market & Government)
- CAHPS Hospital Survey (AHRQ)
- Clinical: Audiology, Speech, PT
- Coding Consulting Service
- Compliance (Medicare)
- Credentials Verification (NCQA)
- EHR & PACS Shared Platforms
- Financial Consulting Service
- H2H (Hospital to Hospital Visits)
- Health Careers Web 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 Strategic Partners

Cooperative Network
La Crosse Medical Health Science Consort.
Marquette University
Medical College of WI
MetaStar, Inc.
National Cooperative of Health Networks
National Rural Health Association
UW School of Medicine & Public Health
UW School of Nursing
UW School of Pharmacy
WI Area Health Education Centers
WI Center for Nursing
WI Collaborative for Healthcare Quality
WI Council on Workforce Investment
WI Dept of Health Services
WI Dept of Workforce Development
WI Dept Safety & Professional Services
WI Hospital Association
WI Health & Educational Facilities Authority
WI Healthcare Data Collaborative
WI Medical Society
WI Office Rural Health
WI Primary Care Association
WI Public Health Association
WI Rural Health Development Council
WI Statewide Health Information Network

Ongoing Myths Lead to Poor Models

- Rural residents don't want to get care locally.
- Rural folks are naturally healthy, need less.
- Rural health care costs are less than urban care.
- AND Rural health care is inordinately expensive.
- Rural quality is lower; urban is better.
- Rural hospitals are just band-aide stations.
- Rural hospitals are poorly managed/governed.

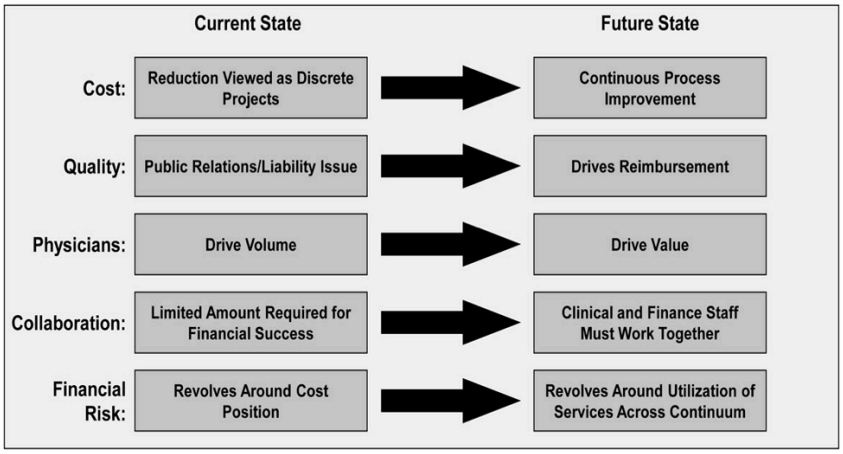


Tension Between Power of Place & Capital

- All providers are more incented to collaborate; so distinction fading: "independent" (power of place) and "system" (power of capital).
- Tele-health offer more choices in where and how rural gains assistance for local care.
- Population health imperative advantages those with strong <u>local</u> connections.
- Shift to primary care will ultimately reduce the disproportionate power of specialty centers.

See "Collaboration Equals Independence" in Jan 2012 issue of *H&HN.*

About Competencies More Than New "Models"



Healthcare Financial Management Association

ACO's Urban Model Can Be Adapted

- There aren't enough beneficiaries & providers in most rural communities to support even one ACO, let alone competing ACOs.
- Many rural communities are located in areas that will have the potential for overlapping ACOs with multiple urban based networks.
- CMS's ACO model should be adapted for local providers to offer their services to multiple ACOs and choice to their community.

"DRG" Spelled "Bundled" is Still Urban?

We need rural relevant incentives to:

- Work in context of a "cost-based" safety net
- Facilitate collaboration among provider types to facilitate Care Transitions.
- Standardize patient information and access to data across the continuum
- Identify/address gaps in post-acute care services

Rural CAH/PPS Valued Based Purchasing

- Resolve to use readily available metrics/data.
- Adopt those rural best practices that are shown to be successful in CMS' upcoming "**Value-Based Purchasing Demonstrations**" & "**Payment Bundling National Pilot Project**."
- Rural need to be proactive with state and third-party payers to identify meaningful quality data sources for use in P4P metrics.

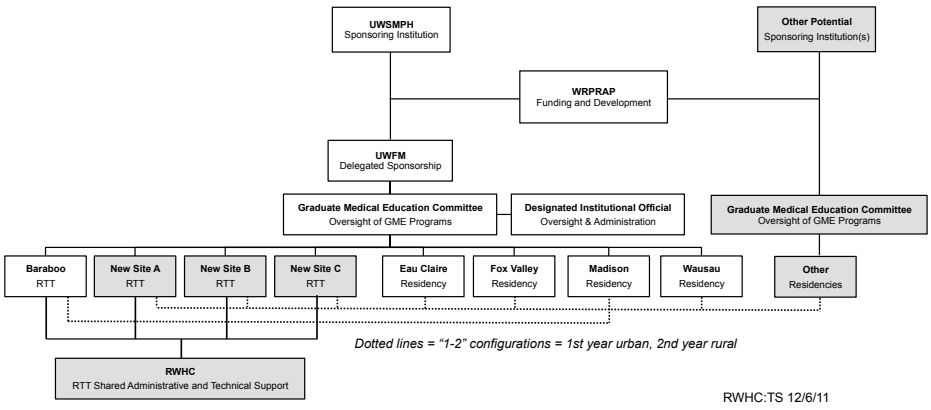
Just a Few More Examples of Rural Models

- EHR Networks (RWHC)
- Health Plan Contracting Networks (RWHC)
- Immunization Consortiums (SWIC)
- GME Collaboratives (WRTTC)
- Rural Telestroke Networks (Illinois)
- Advanced Directive Campaigns (La Crosse, WI)
- Upcoming participation in CMS's "Partnership for Patients" (incl. emphasis Care Transitions)
- Community Collaboratives (New RWJ Prize)

Collaboration Can Bring GME to Rural

Wisconsin Rural Training Track Collaborative

UWSMPH and/or other potential sponsoring institutions.



$25,000 "Roadmaps to Health" Prizes

- RWJ Foundation & UW Population Health Institute will give up to six awards
- To honor successful efforts; inspire, stimulate local coalitions to improve community health
- Applicant: any town, city, county, region or tribe
- Demonstrate health improvement through partnerships & progress measured.
- Details to have been available on April 3rd.

www.countyhealthrankings.org/roadmaps

Advocacy for Rural/Community Perspective

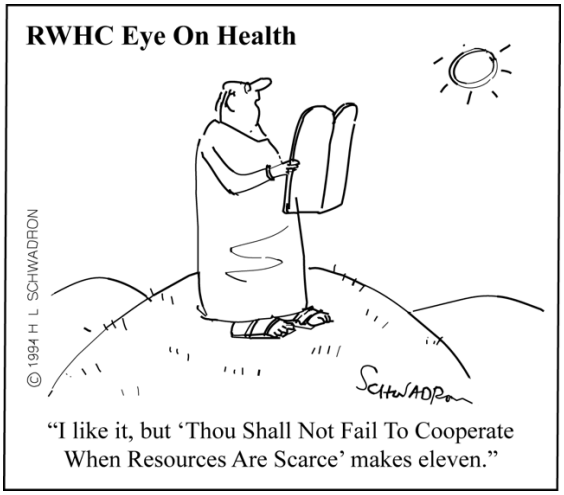
1. Federal **Healthcare Reform** that recognizes rural realities.
2. Fair **Medicare & Medicaid** payments to rural providers.
3. **Federal & State regulations** that recognize rural realities.
4. Solve growing **shortage of rural physicians and providers**.
5. Bring a rural voice into the **quality improvement** movement.
6. Bring a rural voice to **EHR & HIT development**.
7. Bring rural voice to **regional provider networks & payers**.
8. Continue push for workplace and community **wellness**.
9. Strong link between **economic development** and rural health.
10. **Retain property tax exemption** for nonprofit providers.

Rural/Community Hometown Advantage

If we meet community need, we are hard to beat.

1. Rural hospitals/providers have the advantage of being able to make change more quickly.
2. There is a depth of passion and dedication that can't be overstated when neighbors are quite literally caring for each other.

Networks Still Have a Long Way to Go



"I like it, but 'Thou Shall Not Fail To Cooperate When Resources Are Scarce' makes eleven."