Community Health: One Perspective
Forty Years in the Making

RWHC Eye On Health

Tim Size
Executive Director
RWHC
Sauk City
Fort HealthCare
June 5th, 2013
Fort Atkinson, WI

“No. Around here, I’ve never heard of any rural backwater or Lake Wobegon.”

Outline of Presentation

I. RWHC Perspective re CAHs & Tweeners
II. Ongoing Change is Story of Health Care
III. Avoiding Reform’s Collateral Damage
IV. Uncertain Status of Affordable Care Act
V. ACO/Exchange Opportunities (Partial List)
VI. Overcoming Barriers to Change

Discussion & Rebuttal Welcomed at Any Time
I. RWHC Perspective re CAHs & Tweeners

RWHC has a long tradition of being entrepreneurial, collaborative and data driven. But above all, our focus has always been to support and speak up for rural health.

Overview of Rural Challenge & Performance

- “The people served by rural hospitals are more likely to report a fair to poor health status, suffer from chronic diseases, lack health insurance, and be heavier, older, and poorer than residents of urban areas.”
- Yet overall, the average cost per Medicare beneficiary is 3.7 percent lower in rural communities than in urban ones, and rural hospitals perform better than urban hospitals on three out of the four cost and price efficiency measures on Medicare Cost Reports.”

“Implications of Proposed Changes to Rural Hospital Payment Designations Policy Brief,” by The National Advisory Committee on Rural Health and Human Services, December, 2012
RWHC Mission, Vision & Structure

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 “advocate of choice” for its Members and (2) develops and manages a variety of products and services.

RWHC at 10,000 Feet

- Founded in 1979.
- RWHC is Non-profit coop owned by 39 rural community hospitals (with net rev ≈ $1.5 B & 2,000 hospital & LTC beds).
- 8 PPS & 29 CAH; ≈ 23 freestanding and 14 system affiliated.
- ≈ 70 employees (≈ 50 FTE).
- ≈ $11M RWHC budget (75% member sales, 17% non-member sales, 6% dues & 2% grants).
RWHC’s Multifaceted Agenda

- Federal healthcare reform appropriate for Wisconsin.
- Fair Medicare and Medicaid payments.
- Federal and State regulations appropriate for Wisconsin.
- Retain property tax exemption for nonprofit hospitals.
- Solve growing shortage of physicians and providers.
- Bring community voice to regional provider networks & payers.
- Bring a community voice to quality improvement movement.
- Continue push for workplace and community wellness.
- Strongly tie economic development and community health.

II. Ongoing Change is Story of Health Care

- 1970s: Regional planners propose consolidation of rural hospitals ➔ blocked; RWHC born as advocate.
- 1980s: HMO explosion with closed networks seen as threat ➔ RWHC starts HMO; Fed anti-trust protection.
- 1980-90s: Shift to Medicare PPS payments closes 100s of rural hospitals ➔ birth of CAHs in 1997.
- 1990s to Today: Growth of MD Maldistribution ➔ WARM, WCRGME & MCW expansion plans.
- 2000: IOM Reports poor quality of health care ➔ Triple Aim of better health and care at lower cost.
Over Long Term: Health Care ➔ Population Health

It’s no longer about what we charge for a hospital visit but what it costs to keep an insured population healthy.

“We must help all reach highest potential for health and reverse the trend of avoidable illness.”*


Both Public & Private Markets Driving Reform

- Top providers along with their patients will **improve individual health**.
- Top providers and communities will “go upstream” to **address factors that influence population health**.
- Top communities will **employ metrics that assess more global outcomes** of population health.
- Top **providers and communities** will **partner to create healthy communities**.
Details Differ: Big Picture Unchanged

<table>
<thead>
<tr>
<th>Current State</th>
<th>Future State</th>
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</thead>
<tbody>
<tr>
<td><strong>Cost:</strong></td>
<td></td>
</tr>
<tr>
<td>Reduction Viewed as Discrete Projects</td>
<td>Continuous Process Improvement</td>
</tr>
<tr>
<td><strong>Quality:</strong></td>
<td></td>
</tr>
<tr>
<td>Public Relations/Liability Issue</td>
<td>Drives Reimbursement</td>
</tr>
<tr>
<td><strong>Physicians:</strong></td>
<td></td>
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<tr>
<td>Drive Volume</td>
<td>Drive Value</td>
</tr>
<tr>
<td><strong>Collaboration:</strong></td>
<td></td>
</tr>
<tr>
<td>Limited Amount Required for Financial Success</td>
<td>Clinical and Finance Staff Must Work Together</td>
</tr>
<tr>
<td><strong>Financial Risk:</strong></td>
<td></td>
</tr>
<tr>
<td>Revolves Around Cost Position</td>
<td>Revolves Around Utilization of Services Across Continuum</td>
</tr>
</tbody>
</table>

Healthcare Financial Management Association

III. Avoiding Reform’s Collateral Damage

*The Ongoing Need for “Myth” Busting about Rural Communities*

- Residents in rural communities don’t want to get care locally.
- Rural folks are naturally healthy, need less.
- Rural health care costs less than urban care.
- AND Rural health care is inordinately expensive.
- Rural quality is lower; urban is better.
- Community hospitals are just band-aid stations.
- Community hospitals are poorly managed and/or governed.
Community Hospitals: Backbone of Rural Health

North Carolina Health Research Policy Analysis Center, 8/12

1,327 CAHs as of 6/30/12

U.S. Hospitals

Percent Hospitals by Type

Urban PPS, 46.1%
Rural PPS, 9.6%
SCH, 6.8%
MDH, 4.0%
RRC, 4.1%
SCH/RRC, 2.5%
CAH, 27.8%

Percent Medicare Payment by Hospital Type

Urban PPS, 83.4%
Rural PPS, 2.9%
MDH, 1.0%
SCH, 2.5%
SCH/RRC, 3.1%
CAH, 2.2%
Rural PPS Hospital Medicare Cuts?

- MOH Expiration - 12% Inpatient Cut to 200 Rural Hospitals
- LVN Expiration - 13% Inpatient Cut to 650 Rural Hospitals
- Sequestration - 2% Cut to All Rural Hospitals
- 25% Cut in DSH Payments to Rural Hospitals (Non-CAH)
- Hold Harmless - 4% Cut in Outpatient Payments
- 5% Cut Uncompensated Care to Rural Hospitals (Non-CAH)

CODING AND DOCUMENTATION CUTS

Source: NRHA
Rural Wisconsin’s Toughest Challenge

Along With Binge Drinking

http://tosh.comedycentral.com/blog/tag/binge/
Where Bars Trump Grocery Stores

![Map showing the distribution of bars and grocery stores across the USA](http://flowingdata.com/)

National Rural Health Snapshot – 2010 (1 of 2)

<table>
<thead>
<tr>
<th>Access to Health Services</th>
<th>Rural % population</th>
<th>Non-Rural % population</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>No form of health coverage (age 18 - 64 years)</td>
<td>20.6</td>
<td>17.0</td>
<td>21.2%</td>
</tr>
<tr>
<td>Needed to see doctor but could not because of cost–past year</td>
<td>15.6</td>
<td>13.6</td>
<td>14.7%</td>
</tr>
<tr>
<td>No personal doctor</td>
<td>18.1</td>
<td>19.3</td>
<td>-6.2%</td>
</tr>
<tr>
<td>No dental care in previous year</td>
<td>35.6</td>
<td>28.3</td>
<td>25.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Behavior/Risk Factors</th>
<th>Rural % population</th>
<th>Non-Rural % population</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Smoker</td>
<td>22.0</td>
<td>17.8</td>
<td>23.6%</td>
</tr>
<tr>
<td>Obese (Body Mass Index ≥30)</td>
<td>30.5</td>
<td>25.9</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

[www.shepscenter.unc.edu/rural/snapshot.html](http://www.shepscenter.unc.edu/rural/snapshot.html)
National Rural Health Snapshot – 2010 (2 of 2)

Age - Adjusted Mortality

<table>
<thead>
<tr>
<th></th>
<th>Rural per 100,000 population</th>
<th>Non-Rural per 100,000 population</th>
<th>Rural Rate Higher Than Non-Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>All - cause</td>
<td>893.8</td>
<td>823.1</td>
<td>8.6%</td>
</tr>
<tr>
<td>Infant (age&lt;1)</td>
<td>755.0</td>
<td>690.9</td>
<td>9.3%</td>
</tr>
<tr>
<td>Diseases of the heart</td>
<td>249.4</td>
<td>230.2</td>
<td>8.3%</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>27.6</td>
<td>24.6</td>
<td>12.2%</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD)</td>
<td>49.0</td>
<td>42.2</td>
<td>16.1%</td>
</tr>
<tr>
<td>Unintentional Injuries (including motor vehicle traffic)</td>
<td>51.9</td>
<td>34.7</td>
<td>49.6%</td>
</tr>
<tr>
<td>Suicide</td>
<td>13.4</td>
<td>10.3</td>
<td>30.1%</td>
</tr>
</tbody>
</table>

www.shepscenter.unc.edu/rural/snapshot.html

County Health Outcome Rankings – 2013
2013 Wisconsin County Health Rankings (Outcomes)

2013 Wisconsin County Health Rankings (Factors)
IV. Uncertain Status of Affordable Care Act

As you may know, a health reform bill was signed into law in 2010. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

![Image of poll results]

Kaiser Family Foundation Tracking Polls

Many ACA Provisions Popular

Percent who say they feel favorable about each of the following elements of the health reform law:

<table>
<thead>
<tr>
<th>Provision</th>
<th>Total</th>
<th>Dem</th>
<th>Ind</th>
<th>Rep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax credits to small businesses to buy insurance</td>
<td>88%</td>
<td>96%</td>
<td>87%</td>
<td>83%</td>
</tr>
<tr>
<td>Close Medicare &quot;doughnut hole&quot;</td>
<td>81%</td>
<td>90%</td>
<td>80%</td>
<td>74%</td>
</tr>
<tr>
<td>Create health insurance exchanges</td>
<td>80%</td>
<td>87%</td>
<td>78%</td>
<td>72%</td>
</tr>
<tr>
<td>Extension of dependent coverage</td>
<td>76%</td>
<td>84%</td>
<td>79%</td>
<td>68%</td>
</tr>
<tr>
<td>Subsidy assistance to individuals</td>
<td>76%</td>
<td>91%</td>
<td>69%</td>
<td>61%</td>
</tr>
<tr>
<td>Medicaid expansion</td>
<td>71%</td>
<td>88%</td>
<td>70%</td>
<td>42%</td>
</tr>
<tr>
<td>Guaranteed issue</td>
<td>66%</td>
<td>75%</td>
<td>67%</td>
<td>56%</td>
</tr>
<tr>
<td>Medical loss ratio</td>
<td>65%</td>
<td>72%</td>
<td>60%</td>
<td>62%</td>
</tr>
<tr>
<td>Increase Medicare payroll tax on upper income</td>
<td>60%</td>
<td>80%</td>
<td>54%</td>
<td>37%</td>
</tr>
<tr>
<td>Employer mandate/penalty for large employers</td>
<td>57%</td>
<td>79%</td>
<td>54%</td>
<td>36%</td>
</tr>
<tr>
<td>Individual mandate/penalty</td>
<td>40%</td>
<td>55%</td>
<td>39%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Kaiser Family Foundation Tracking Polls
## Awareness of ACA Provisions

To the best of your knowledge, would you say the health reform law does or does not do each of the following?

<table>
<thead>
<tr>
<th>Provisions</th>
<th>CORRECT</th>
<th>INCORRECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual mandate/penalty</td>
<td>74%</td>
<td>17%</td>
</tr>
<tr>
<td>Employer mandate/penalty for large employers</td>
<td>71%</td>
<td>17%</td>
</tr>
<tr>
<td>Extension of dependent coverage</td>
<td>69%</td>
<td>20%</td>
</tr>
<tr>
<td>Subsidy assistance to individuals</td>
<td>62%</td>
<td>29%</td>
</tr>
<tr>
<td>Medicaid expansion</td>
<td>59%</td>
<td>25%</td>
</tr>
<tr>
<td>Health insurance exchanges</td>
<td>58%</td>
<td>29%</td>
</tr>
<tr>
<td>Increase the Medicare payroll tax on upper income</td>
<td>54%</td>
<td>27%</td>
</tr>
<tr>
<td>Guaranteed issue</td>
<td>53%</td>
<td>36%</td>
</tr>
<tr>
<td>Tax credits to small businesses to buy insurance</td>
<td>52%</td>
<td>26%</td>
</tr>
<tr>
<td>Close Medicare “doughnut hole”</td>
<td>46%</td>
<td>31%</td>
</tr>
<tr>
<td>Medical loss ratio</td>
<td>40%</td>
<td>37%</td>
</tr>
</tbody>
</table>

## Misperception of Provisions NOT in the Law

To the best of your knowledge, would you say the health reform law does or does not do each of the following?

<table>
<thead>
<tr>
<th>Provisions</th>
<th>CORRECT</th>
<th>INCORRECT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cut benefits for people in Medicare</td>
<td>43%</td>
<td>44%</td>
</tr>
<tr>
<td>Establish a government panel to make decisions about end-of-life care for people on Medicare</td>
<td>39%</td>
<td>40%</td>
</tr>
<tr>
<td>Allow undocumented immigrants to receive subsidies to purchase insurance</td>
<td>33%</td>
<td>47%</td>
</tr>
<tr>
<td>Public option</td>
<td>28%</td>
<td>57%</td>
</tr>
</tbody>
</table>
### Expectations ACA’s Impact on Cost and Quality

Under the health reform law, do you think each of the following will get better, worse, or will it stay about the same?

#### NATIONAL IMPACTS

<table>
<thead>
<tr>
<th>Area</th>
<th>Worse</th>
<th>Stay about the same</th>
<th>Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>The cost of health care for the nation as a whole</td>
<td>55%</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>The quality of health care in the nation</td>
<td>45%</td>
<td>26%</td>
<td>24%</td>
</tr>
<tr>
<td>Consumer protections for the average person with private health insurance</td>
<td>39%</td>
<td>36%</td>
<td>16%</td>
</tr>
<tr>
<td>Access to health care for the uninsured</td>
<td>28%</td>
<td>24%</td>
<td>40%</td>
</tr>
</tbody>
</table>

#### PERSONAL IMPACTS

<table>
<thead>
<tr>
<th>Area</th>
<th>Worse</th>
<th>Stay about the same</th>
<th>Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>The cost of health care for you and your family</td>
<td>45%</td>
<td>33%</td>
<td>22%</td>
</tr>
<tr>
<td>The quality of your own health care</td>
<td>34%</td>
<td>48%</td>
<td>15%</td>
</tr>
<tr>
<td>Your ability to get and keep health insurance</td>
<td>28%</td>
<td>48%</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Kaiser Family Foundation Tracking Polls*

### Health Insurance Exchanges

- **Exchange Decision**
  - Default to Federal Exchange
  - Declared State-based Exchange
  - Planning for Partnership Exchange

*Washington Post, 3/23/13*
Obamacare’s 5 Big Challenges Impact Rural

1. **Extending the scope of Medicaid expansion.** Was was to cover 17 million. When the Supreme Court ruled states could opt out, many took up the option.

2. **Building the health-insurance marketplaces.** The health-insurance exchanges are Obamacare’s backbone. These are the online marketplaces—something like an Expedia for health coverage—where Americans can shop for private insurance or Medicaid coverage.

3. **Getting the word out about the health law’s new program(s).** Polls of low- to middle-income Americans whether they were aware of the new law’s provisions. Seventy-eight percent were not.

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Obamacare’s Five Biggest Challenges

4. **Swaying public opinion on Obamacare.** Ever since the ACA became law in 2010, public opinion has remained stubbornly split. The same number (40 percent) oppose it now as did three years ago. Favorable ratings, meanwhile, have fallen by 9 percent.

5. **Controlling health-care costs.** It’s one thing to hand out health-insurance cards; that’s relatively easy. It’s quite another to ensure that an insurance card guarantees access to affordable health care.
Related Issue: The Medicaid Expansion

As you may know, the health care law expands Medicaid to provide health insurance to more low-income uninsured adults. The federal government will initially pay the entire cost of this expansion, and after several years, states will pay 10 percent and the federal government will pay 90 percent. The Supreme Court ruled that states may choose whether or not to participate in this expansion. What do you think your state should do?

Keep Medicaid as it is today  Expand Medicaid to cover more low-income people

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<thead>
<tr>
<th></th>
<th>Total</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>41%</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>Democrats</td>
<td>20%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Independents</td>
<td>46%</td>
<td>44%</td>
<td></td>
</tr>
<tr>
<td>Republicans</td>
<td>67%</td>
<td>26%</td>
<td></td>
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Kaiser Family Foundation Tracking Polls

The Health Insurance Exchange & Medicaid

- **Governor’s initial plan** will cost WI taxpayers at least $63 Million over next 3 years with **9,000 fewer Medicaid enrollees**. Gives up $910 Million in Federal Medicaid funding to State over 3 years.

- **The proposed plan** depends on the Exchange start-up working for 180,000 low income people (vs. 55,000 for 133% FPL option) ➞ **high risk of uncompensated care**.

- **Coverage to 133% FPL** will save WI taxpayers up to $147 Million over next 3 years and allows for **117,000 more Medicaid enrollees**. Brings additional $1 Billion in Federal Medicaid funding to State over 3 years.
V. ACO/Exchange Opportunities (Partial List)

Community health is driven by political and market forces incenting the Triple Aim (to lower costs, to improve individual health care and population health).

Accountable Care Organization 101 (1 of 2)

- **ACOs** are voluntary groups of doctors, hospitals, and other health care providers giving coordinated quality care to Medicare patients.

- Goal of coordinated care is to ensure that patients, especially the chronically ill, get right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

- When an ACO succeeds in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for Medicare.

  www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/
Accountable Care Organization 101 (2 of 2)

- **Medicare offers 3 ACO programs:** (1) *Medicare Shared Savings Program*—a program for Medicare fee-for-service program providers, (2) *Advance Payment ACO Model*—a supplementary incentive program for selected participants in the Shared Savings Program. (3) *Pioneer ACO Model*—a program designed for early adopters of coordinated care.
- Participating in an ACO is **voluntary for providers**.
- Fee-for-service Medicare patients maintain all their rights, including right to choose their providers.

[www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/](www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/)

The Exchange & Insurers

**Goal: Decrease Uninsured and decrease costs will:**

- **Increase market share in public and private exchanges:** think booking a hotel on Expedia or an airplane ticket on Kayak versus using a travel agent.
- Cause health plans to **design products to attract and care for healthy** people.
- See growth in tiered health plans that give people an **incentive to go to hospitals that provide overall quality care at the lowest cost** (example: United).
Community Impact to Exchange Incentives

**Insurer financial success in exchanges depends on:**

- Create products to attract healthy people (community disadvantage as healthier people may be incented to migrate to plans in urban/suburban markets?)
- Adequate risk adjustment to fairly compensate health plans with higher risk patients (will Feds adequately protect markets with older, sicker patients; indirect continuation shift of funds to FLA, CA & NY?)
- Manage chronic conditions better than other health care organizations (community has the resources to do as aggressively as will be needed?)

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Healthcare Delivery System Reform

Reform Bill uses $ incentives that will significantly impact hospitals (more than mandates) to Improve the delivery system.
Reform: Paying for Value

- Service will be accessed based on patient experience, care quality, and delivery efficiency.
- **Health care value, not simply service volume, will drive payment.**
- Rural health care systems will be organized around a robust primary care base.
- The focus will be on care in the community, supported by the hospital–anchored in primary care.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

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Reform: Collaborating to Integrate Services

- Collaborative providers will deliver the continuum of care seamlessly to patients.
- Rural providers will collaborate locally for improved health outcomes and better financial performance.
- Rural providers will collaborate vertically to ensure timely access to services not available locally.
- **Urban** systems will collaborate with rural health systems to meet performance and financial goals.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11
Reform: Information Used to Manage Care

- **Patients engaged in their own care plans** (patient responsibility promoted by the system) and patient needs met (better care).
- **Seamless transfer** of clinical and administrative information among providers.
- Health information readily available in rural places and understandable to individual patients.
- **Transparency of health care cost and quality information**, access to proactive disease management and prevention assistance.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

Reform: Healthy People / Healthy Communities

- Providers and patients will connect to community health **resources to improve individual health**.
- Providers and the community will "**go upstream**" to **address factors that influence population health**.
- In concert with clinical quality and efficiency metrics, rural **communities will employ metrics that assess these more global outcomes**.
- Rural **providers and their communities will partner** in creating healthier communities.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11
Honoring Choices

- **Wisconsin Medical Society takes up variation on theme championed early by Gundersen Lutheran**
- Advance care planning as a process of planning and communication, with conversation at its core
- **Facilitated advance care planning conversations a routine part of health care for all capable adults**
- Working with diverse people to create environment in which the conversation is normalized and thrives
- Ensuring that advance care planning documents are properly stored and retrievable in all settings.

Longstanding Issue: Coverage ≠ Access

Current workforce shortages hit rural first, harder and longer:
- Primary Care,
- Dental,
- Mental Health,
- EMS

**Coming Our Way**
- General Surgery
- Nursing ...

“The idea of the country investing in physician training is to get them where we need them, not where they would go anyway.”
PROJECTED NEED FOR PHYSICIANS

“By 2020, our nation will face a serious shortage of both primary care and specialist physicians. The shortfall will be most severe on vulnerable and underserved populations. Unless we act now, America will face a shortage of more than 90,000 doctors in 10 years.”
-- Association of American Medical Colleges
June 2010

“Wisconsin will need to add 100 new physicians annually to avoid an expected shortfall of 2,000 by 2030. The need is most urgent in primary care, general surgery and psychiatry -- in both rural and underserved urban areas.”
-- Wisconsin Hospital Association
November 2011

“If students complete both their medical education and residency training in Wisconsin, nearly 70% will remain in the state to practice medicine.”
-- AAMC State Physician Workforce Data Book
December 2011

* The green shaded areas denote federally-designated rural and urban locations where there are significant shortages of primary care physicians


Healthcare Reform ≠ Health

“We must provide education and preventive care, 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.”

As part of the Triple Aim, rural providers increasingly looking at both individual healthcare and ways to improve the overall health of their community

2012 Wisconsin County Health Rankings Model, University of Wisconsin Population Health Institute

Business Leaders Increasingly See Big Picture

WMC (Wisconsin Manufacturers & Commerce) encourage their members to think about community sustainability:

- “consider the entire life cycle of the product and of physical assets;
- consider the effect on the community infrastructure;
- environmental solutions must have a business purpose and bring value to the business;
- you must have passion for it and enable staff to be innovative.”

The companies WMC has identified with “best practices” are successful partly because of their passion for sustainability, not in spite of it.”

http://www.wmc.org/
Rural Health’s Two-fer: Health & Jobs

Rural health is all about the natural tension between the power of capital and the power of place.

This makes rural health dependent on the local community, local employers, local schools & vice versa.

Jobs Depend on Rural Health (1 of 2)

- Local rural health = local health care jobs.
- People often know that business relocation decisions are influenced by the cost and quality of health care available locally.
- But as or more importantly, rural health has the same economic impact as export commodities like milk, soy beans or rural based manufactured goods because of its ability to bring dollars and jobs into the community.
Jobs Depend on Rural Health (2 of 2)

- Rural insurance premiums and taxes only come back to circulate in the community and create jobs if there are local health care providers there (and people use them) to attract those dollars.

- For every 2 jobs created (or lost) in rural health care, the number of jobs in other local businesses increase (or decrease) by at least 1 job.

- The rural economy and health of rural communities is extremely dependent on WHERE health care dollars are spent.

RWJF Roadmaps to Health Prize (1 of 2)

Harnessing The Collective Power Of Leaders, Partners, and Community Members by listening to diverse voices, inspiring each other and developing strategies for buy-in, decision-making, and coordinated action among groups.

Implementing A Strategic Approach To Improving Health That Focuses On The Multiple Factors That Influence Health including health behaviors, clinical care, social and economic factors, and the physical environment.
RWJF Roadmaps to Health Prize (2 of 2)

Addressing Problems That Disproportionately Affect Vulnerable Populations and creating opportunities for all members of the community to make choices allowing them to live a long healthy life.

Developing Sustainable, Long-term Solutions to Shared Community Priorities including planning and implementing policy, systems and environmental changes that target populations.

Securing & Making the Most of Available Resources Measuring and Sharing Results.

VI. Overcoming Barriers to Change

*Get over the Doc Welby thing, what you do makes a lot more difference to your health than what I do.*
Deeply Ingrained Baises

"No need to pay rural more when they have always managed with less."

Politics Trump Policy & Research

Both public and private policy makers have constituencies that drive the process more than the best data or policy.

“Tell me again how this works for people to re-elect me.”
Elected & Appointed Officials Can Be At Odds

RWHC Eye On Health

“No need to rebuild old rural hospitals when we have perfectly good Army surplus MASH tents.”

 Tradition Conceals Important Questions

RWHC Eye On Health

“Why do we try not to chop off infected toes but we routinely pull out ‘bad’ teeth.”
Challenge of Smaller Data Sets

ACO focus on financial and quality reporting designed for large organizations creates a statistical challenge for smaller hospitals and physician groups.

Fear Often Trumps Hope & Delays Change

Machiavelli & Thomas Jefferson both understood that change required “that the hope of gain be greater than the fear of loss.”
Don’t Underestimate Economic Self Interest

“Community Health: One Perspective 40 Years in the Making,” Tim Size
Fort HealthCare, June 5th, 2013

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Recommendation #2: Follow Your Passion

"Yes, I'm a generalist. I chose primary care over being a partialist."

Recommendation #3: Vision Matters

"I knew I was going to take the wrong train, so I left early." (Yogi Berra)
Rural Health Resources

- **RWHC Web:** [http://www.rwhc.com/](http://www.rwhc.com/)
- **Wisconsin Office of Rural Health:** [http://worh.org/](http://worh.org/)
- For the free **RWHC Eye on Health e-newsletter**, email [office@rwhc.com](mailto:office@rwhc.com) with “subscribe” on subject line.
- **Rural Assistance Center** at [www.raonline.org/](http://www.raonline.org/) is an incredible federally supported information resource.
- The **Health Workforce Information Center** is RAC’s new “sister” for health workforce programs, funding, data, research & policy [www.healthworkforceinfo.org/](http://www.healthworkforceinfo.org/)