Advocating for Collaborative Rural Health: One Perspective, 35 Years in the Making

Intro: Rural Change Comes in Waves

- 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.
“We must **help all reach highest potential for health and reverse the trend of avoidable illness.** * Multiple forces along with the IRS mandated community assessment is leading to major new opportunities for hospital and public health partnerships.


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**Rural Future: Collaborating to Create Health**

- Providers and patients need to connect to community health resources to **improve individual health.**
- Providers and the community need to “go upstream” to **address factors that influence population health.**
- Rural communities need to **employ metrics that assess more global outcomes** of community health.
- Rural **providers** and their **communities** need to **partner in creating health.**

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

I. Brief Intro to Rural Wisconsin Health Cooperative
II. Overview of Rural Health As Now Is
III. Examples Where Collaboration Needed
IV. Recommendations for Collaboration
V. Rural Advocacy: Making the Invisible Visible
VI. Discussion/Rebuttal

Please feel free to speak up at anytime.

I. Brief Intro to RWHC

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

Synergy Between Advocacy & Service

RWHC Services Support Advocacy Role:

- External Credibility
- Similar Infrastructure
- Profits Subsidize Advocacy
- Inform Advocacy; Early Warning Sign for Issues
- Advocacy Needed Not Just with Government but in Marketplace and with Academe
RWHC at 10,000 Feet

- Founded in 1979.
- RWHC is Non-profit coop owned by 38 rural hospitals (with net rev ≈ $1.4B & 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 Shared Services*

**Professional Services**
- Financial & Legal Services
- Coding Audits/Review
- Negotiation with Health Insurers
- Clinical Services & Recruitment

**Educational Services**
- Professional Roundtables & Leadership Training
- Nurse Residency Program & Preceptor Workshops
- Lean Lab (with Lean Six Sigma Master Black Belt)

**Quality Programs**
- Credentials Verification Organization (NCQA Certified)
- Quality Indicators Reporting (The Joint Commission Approved)
- Patient Satisfaction Surveys (CMS approved vendor)

**Technology Services**
- Data Center Services
- Electronic Medical Records & Technology Management

* Partial List
RWHC’s Multifaceted Rural Agenda

- Federal healthcare reform that recognizes rural realities.
- Fair Medicare and Medicaid payments to rural providers.
- Federal and State regulations that recognize rural realities.
- Retain property tax exemption for nonprofit hospitals.
- Solve growing shortage of rural physicians and providers.
- Bring rural voice to regional provider networks & payers.
- Bring a rural voice into the quality improvement movement.
- Continue push for workplace and community wellness.
- Strong link between economic development and rural health.

RWHC Focus on Strategic Partnerships

- Cooperative Network
- Federal Office of Rural Health Policy
- La Crosse Med. Health Science Consort.
- Marquette University
- Medical College of WI
- MetaStar, Inc.
- National Cooperative of Health Networks
- National Rural Health Resource Center
- 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 & Ed. 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 Info. Network
II. Overview of Rural Health As Now Is

There is an Ongoing Need for Rural “Myth” Busting

- Rural residents 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.
- Rural hospitals are just band-aid stations.
- Rural hospitals are poorly managed and/or governed.

Rural 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

Percent Medicare Payment by Hospital Type

USA Less Rural & Rural Farms Less

Population by Rural and Farm Residence, Wisconsin: 1850 to 2000

Gary Paul Green, UW-Madison/Extension
Presentation in Mosinee, 1/12-13/06
### National Rural Health Snapshot – 2010 (1 of 2)

#### Access to Health Services

<table>
<thead>
<tr>
<th>Issue</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>28.5</td>
<td>25.8%</td>
</tr>
</tbody>
</table>

#### Health Behavior/Risk Factors

<table>
<thead>
<tr>
<th>Issue</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>-17.0%</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>Cause</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>493.8</td>
<td>823.1</td>
<td>8.0%</td>
</tr>
<tr>
<td>Infant (age&lt;1)</td>
<td>755.0</td>
<td>600.0</td>
<td>9.3%</td>
</tr>
<tr>
<td>Diseases of the heart</td>
<td>249.4</td>
<td>240.2</td>
<td>3.5%</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>27.6</td>
<td>24.6</td>
<td>12.3%</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](http://www.shepscenter.unc.edu/rural/snapshot.html)
County Health Outcome Rankings – 2013

2012 Wisconsin County Health Rankings (Outcomes)
This Dental HPSA map is valid as of June 2012. The map illustrates the general location of shortage areas eligible for state loan repayment; please see the WI Primary Care Office web site (http://dhs.wisconsin.gov/health/primarycare/ShortageDesignation.htm) for more detailed information on shortage areas and associated benefits.

This Primary Care HPSA map is valid as of June 2012. The map illustrates the general location of shortage areas eligible for state loan repayment; please see the WI Primary Care Office web site (http://dhs.wisconsin.gov/health/primarycare/ShortageDesignation.htm) for more detailed information on shortage areas and associated benefits.
Slowly Wisconsin is Less Proud of This First Binge Drinking

http://tosh.comedycentral.com/blog/tag/binge/

Rural Wisconsin’s Toughest Challenge

http://dhs.wisconsin.gov/health/primarycare/ShortageDesignation.htm

Tosh, 880 Independence Lane, Sauk City, WI 53583  (T) 608-643-2343
Email: timsize@rwhc.com World Wide Web Site: www.rwhc.com Tweet: www.twitter.com/RWHC
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.

III. Examples Where Collaboration Needed

Rural Health is not exempt from political chaos and the alignment of forces driving reform to improving population health, individual health care, and lower costs (the Triple Aim).
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

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.

Medicaid: Building on Governor’s Proposal

- **Governor’s initial plan will cost WI taxpayers an additional $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.

Wisconsin Legislative Fiscal Bureau
Critical Access Hospital Medicare Cuts?

- CAH REIMBURSEMENT CUTS — (President’s budget)
- ELIMINATION OF CAH STATUS FOR NEARLY 50 HOSPITALS (President’s budget)
- SEQUESTRATION - 2% CUT TO ALL RURAL HOSPITALS
- PROPOSED CUTS IN FLEX AND OUTREACH GRANTS
- PROPOSAL TO ELIMINATE ALL CAHs (CBO budget proposal)
- 35% CUT UNCOMPENSATED CARE
- PROVIDER TAX (ASSESSMENT) CUTS

Source: NRHA

Public & Private Sector Market Reform (1 of 2)

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).
Public & Private Sector Market Reform (2 of 2)

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

- Create products that attract healthy people (*rural 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 rural markets with older, sicker patients; indirect continuation shift of funds to FLA, CA & NY?*)
- Manage chronic conditions better than other health care organizations (*do rural have the resources to do as aggressively as will be needed?*)
UW Earlier Stepped Up Re Rural MDs

**AHEC**
- Prepare elementary/high school students in basic science and expose to role models

**WARM: WI Academy for Rural Medicine**
- Recruit students with rural background and career goals
- Locate education and training programs in rural areas of WI
- Use rural appropriate curriculum

**WORH/GME**
- Facilitate graduates seeking training and employment in rural WI
- Grow rural WI health care workforce

*Wisconsin Rural Pipeline (adapted from recent IOM report)*
From talk by Dean Robert Golden to RWHC Board, 2/1/13

**MCW TIMELINE: PROGRAM DEVELOPMENT**

<table>
<thead>
<tr>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversations, Outreach, and Relationship building with Health System and Academic Partners</td>
<td>Developed Initial Program Vision and Conducted Feasibility Study</td>
<td>Campus Dean Recruitment</td>
<td>Student recruitment</td>
<td>Matriculation of first class of students</td>
<td>First class graduates and enters residency</td>
</tr>
<tr>
<td>Interviews with National Programs</td>
<td>Issued Call for Partners</td>
<td>Development of Community Advisory Board</td>
<td>Faculty development</td>
<td>Program Evaluation</td>
<td></td>
</tr>
<tr>
<td>Focus groups with MCW Board, Faculty Students, and Staff</td>
<td>Selected Regional Partners and Campus sites based on proposals and site visits</td>
<td>Submit LCME Application</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Launched Strategies to Maintain Community Engagement</td>
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</tbody>
</table>

RWHC, 880 Independence Lane, Sauk City, WI 53583   (T) 608-643-2343
Email: timsize@rwhc.com  World Wide Web Site: www.rwhc.com  Tweet: www.twitter.com/RWHC
Rural GME Choke Point in Physician Supply

Wisconsin Collaborative for Rural Graduate Medical Education Partnership with Wisconsin Rural Physician Residency Assistance Program
Funded by the CAH Assessment & Opportunity for UWSMPH and/or other potential sponsoring institutions.

Rural GME Choke Point in Physician Supply

Too Many Parents Believe in Herd Immunity

- Dean & Unity Health admin. data showed that for 2010 the combined Childhood Immunization Status rate for children age two in urban Dane County was 77% and the average in the rural counties studied was 66%. The HEDIS benchmark for 90% percentile is a rate of 89%.
- There are many immunization collaboratives in Wisconsin, some serving a single county, others more, all promoting immunizations.
- RWHC started SWIC with belief that sharing of best practices will greatly support increased immunization rates.

RWHC, 880 Independence Lane, Sauk City, WI 53583  (T) 608-643-2343
Email: timsize@rwhc.com  World Wide Web Site: www.rwhc.com  Tweet: www.twitter.com/RWHC
Promoting Advanced Directives

- **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.

IV. Recommendations for Collaboration

Caveat:
Collaboration needed both within and between organizations and sectors.
Collaboration & Advocacy Use Similar Steps

TAKE ACTION

Source: Roadmaps to Health Action Center

Link at end of this PPT

One View of the Collaborative Continuum

Trust & Time   ▶️   Coordinate   ▶️   Cooperate   ▶️   Collaborate

Network: 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
### A Checklist for Successful Collaborating

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

"The Collaboration Primer" by Gretchen Williams Torres and Frances Margolin

### Rec. #1: Partnership Proposals 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 had 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.
Rec. #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 dominated by one entity.

Rec. #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.”
Rec. #4: Communication is Core Competency

- Everyone Participates, No One Person Dominates
- Listen As An Ally—Work To Understand Before Evaluating
- An Individual’s Silence Will Be Interpreted As Agreement

Rec. #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.

Recommend read a classic on collaborative leadership: “Leadership Is an Art” by Max Depree (At the time, the CEO of the Herman Miller furniture company.)
Rec. #6: Balanced Portfolio

<table>
<thead>
<tr>
<th>Risk</th>
<th>Value Added</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>L - L</td>
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<tr>
<td>L</td>
<td>L - H</td>
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<tr>
<td>H</td>
<td>H - H</td>
</tr>
</tbody>
</table>

**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** and “High Risk - High Value Added” **provides real value over the long run.**

Rec. #7: Seeking the Win-Win is Necessary

“Try Saying ‘Yes, if …’ rather than ‘No, because...’”

*Anne Woodbury, Chief Health Advocate for Newt Gingrich’s Center for Health Transformation*
V. Rural Advocacy: Making the Invisible Visible

Government and organizations driving policy are usually urban based, much of rural advocacy is dealing with myths. But our incredibly dysfunctional government also brings increasing challenge of rural not becoming collateral damage.

What is Advocacy?

- It is not restricted to or mostly lobbying.
- Advocacy is working for a desired future.
- It can be on behalf of self, one or two others, or the state, nation or world.
- It may be in public or private sectors or both.
- It may be done alone or with others.
Examples of What Drives Advocacy

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

Strategic Barriers to Getting Involved

• Resources. Providers struggling to address traditional responsibilities with tight budgets are not looking for new roles “that no one will pay us to do.”

• Tradition. The role of providers has been seen as treating individual patients. Population health seen as the job of public health departments.

• Values. The discomfort that most of us feel when talking about individual behaviors–other people’s choices and their freedom to make those choices.

“Population Health Improvement & Rural Hospital Balanced Scorecards,” Journal Rural Health, Spring, 2006
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 Two Sides - there are voters on other side
- Be Courteous/Never Threaten
- Be Patient - long process; be in for long haul

Wisconsin Hospital Association’s “Grass Roots Handbook”

Three Prong Advocacy Strategy

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

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

Make it happen: Use all of your advocacy tools—government relations, grassroots and media.
Politics Trump Policy & Research

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

Elected & Appointed Officials Can Be At Odds

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

Why do we try not to chop off infected toes but we routinely pull out 'bad' teeth.

Rural Faces Challenge of Smaller Data Sets

The increased focus on quality reporting and outcome metrics designed for large organizations creates a statistical challenge for many rural hospitals and physicians.
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

“We don’t have to tackle healthcare reform until voters’ hope of gain outweighs their fear of loss.”

“That’s where you’re wrong, we are businessmen first, denials second.”
Bottom Line: Follow Your Passion

RWHC Eye On Health

“Yes. I’m a generalist. I chose primary care over being a partialist.”

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 with “subscribe” on subject line.
• Rural Assistance Center at [www.raconline.org/](http://www.raconline.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/)