Three Questions

1. What is today’s rural context?
2. During a time of political chaos and systemic health care change, what are our core values?
3. How do we bridge the polarization of rural/urban, conservative/liberal, race/ethnicity...?
Part 1 - What is the Rural Context?

The Rural Issues We Fight For

1. Equitable Medicare/Medicaid Funding
2. Health Plan Network Adequacy
3. Rural Relevant “Volume to Value” Incentives
4. Avoiding Rural Collateral Damage as Giants Battle
5. The Needed Statewide Workforce
6. Physician/Staff Engagement
7. The Effective Use of All Caregivers
8. Rural Economic & Community Growth
Network Adequacy Top Non-Federal Priority

- Health plan does **not offer a contract** with local hospital.
- Health plan offers a contract at **only Medicaid rates** or admits that they really don’t need or want a contract.
- Health plan has contracted with the hospital, but **does not contract with or credential employed physicians**.
- Hospital has a contract with health plan, but **no one is referred** to the hospital.
- Health plan **contracts only with the clinic**, but not the specialists or hospital affiliated with the community clinic.
- Contracted providers are **not listed as available**.

Source: Wisconsin Hospital Association
Network Adequacy Council

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Rural is Older, Poorer, and Sicker

“Americans living in **rural** communities are **more likely to die prematurely from the top five causes of death** (heart disease, accidents, stroke, cancer, and respiratory disease), than are their urban counterparts.”

“Healthy People 2020’s five self-reported **health-related behaviors are lower in rural counties** (sufficient sleep, current nonsmoking, nondrinking or moderate drinking, maintaining normal body weight, and meeting aerobic leisure time physical activity recommendations).”

CDC Morbidity and Mortality Weekly Report (MMWR)
Rural Health Series, 2017
The map shows the distribution of Wisconsin’s health outcomes based on an equal weighting of length and quality of life.

University of Wisconsin Population Health Institute
County Health Rankings 2016
Part 2 - What Are Our Core Values?

RWHC Eye On Health

“You’re too dumb to understand why I’m right and you’re wrong, even if I could explain it.”

Equity Doesn’t Always Mean Equal

http://culturalorganizing.org/
The Clinician-Patient Relationship is Primary

1. Need for Trust
2. Commitment to Responsibility, Perseverance
3. Guide through the Maze
4. Ability to say NO
5. Ability to Make Exceptions
6. Payment System Not based on Throughput

Source: John Frey, MD, Friend & Family Medicine Pioneer

Patient Focused Language

<table>
<thead>
<tr>
<th>Try this...</th>
<th>Instead of...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of care over quantity of services</td>
<td>Value over volume</td>
</tr>
<tr>
<td>Patient-focused Care</td>
<td>Value-based Care</td>
</tr>
<tr>
<td>Individuals, Patients</td>
<td>Consumers</td>
</tr>
<tr>
<td>Coordinated Care, Care Coordination</td>
<td>Managed Care</td>
</tr>
<tr>
<td>Engaged, Empowered</td>
<td>Educated</td>
</tr>
<tr>
<td>Delivering quality care without patients paying more</td>
<td>Cutting costs, Efficient care</td>
</tr>
<tr>
<td>Doctors, Nurses, Clinicians</td>
<td>Providers, Medical teams</td>
</tr>
</tbody>
</table>

Recommendations to QIOs, 2/17
System Partnership Behaviors Matter

1. A Partnership/Network Is a Unique Business Model
2. Like Politics, All Partnerships/Networks Are Local
3. Non-Profit Still Needs to Be Entrepreneurship
4. Partnership/Network Sustainability Starts Yesterday
5. Partnerships/Networks Are Advocates

Part 3 - How Do We Reduce Polarization?
Rural Resentment of Urban Places - 1 of 2

- Madison/Milwaukee vs. “Outstate”
- “Madison” = university and legislature
- Madison/Milwaukee is the resource suck
- Power emanates from Madison, not the reverse

Lack of respect and understanding of small town Wisconsinites

From a PPT by Kathy Cramer, Morgridge Center for Public Service, Dept. of Political Science, UW-Madison for WCHQ Assembly, 1-17-17

Rural Resentment of Urban Places - 2 of 2

Rural consciousness

- Identity as a rural person, choose to be so
- Decision making power in the cities
- Rural areas ignored and disrespected

From a PPT by Kathy Cramer, Morgridge Center for Public Service, Dept. of Political Science, UW-Madison for WCHQ Assembly, 1-17-17
Paul Maslin, political strategist, pollster and Democrat, in the Wisconsin State Journal, 2/20/17

“Talk With People Where They Live”

Rural/Urban Not Either/Or - 1 of 4

“Substantial attention has focused on the higher rates in certain communities for adverse health outcomes, such as mortality and low birth weight, and health determinants such as obesity, poverty, or inadequate insurance coverage. But the relative burden on different populations that these rates produce are not always discussed and has implications on health policy.”

“This focus on rates has led to a prevalent view that health equity refers primarily to racial health equity, and often only refers to African American health equity.”

“Population Health Equity: Rate and Burden, Race and Class” by David Kindig, MD, PhD in JAMA, 2/7/17
“The total burden of poor health, even within lower socioeconomic groups, is greater among white individuals than black individuals, simply because there are more whites than black of lower socioeconomic status. The higher racial rates, as unacceptable as they are, do not produce a greater burden of poorer health in the US population since burden is measured in absolute rather than relative terms.”

An example:

“According to data from the Centers for Disease Control and Prevention (CDC), the mortality rate to age one in 2013 for infants of mothers with less than a high school education is 11.6 per 1000 live births among blacks vs 8.8 per 1000 live births among whites.

“The total number of black infant deaths is 1013 whereas total number of white infant deaths is 1337.”
Rural/Urban Not Either/Or - 4 of 4

“...a minimum level of resources for health determinants would be appropriate for the entire population but this level would need to be increased for populations with higher rates of an outcome above the baseline level.”

“High rates of poor health are critical indicators for policy priority... seeking support for health policies that help both poor black people and poor white people could garner more broad-based support than policies that solely address racial gaps.”

“Population Health Equity: Rate and Burden, Race and Class”
by David Kindig, MD, PhD in JAMA, 2/7/17

Hyper Partisan Politics Drives Polarization

“RWHC Eye On Health

“To cite Mark Twain: ‘In the first place, God made idiots. That was for practice. Then he made your party.’ ”
“Seven Habits of Highly Depolarizing People”*

1. **Criticize from within** – Lincoln’s 1st Inaugural address “the better angels of our nature” or both rural and urban face systemic issues.

2. **Look for good in conflict** - CMS & rural both want quality/access

3. **Count higher than two** - Say “yes if” rather than “no because”

4. **Doubt** - “I’d rather have a beer with someone who’s searching for truth than with someone who’s found it.” (playwright Václav Havel)

5. **Specify** - Avoid “rurals are hicks” and “urbans are hippies” cartoon

6. **Qualify** – Kindig’s synthesis “total burden” and “high rates”

7. **Keep the conversation going** – Cramer’s active listening

* by David Blankenhorn in the American Interest, 2/17/16

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**Going Forward**

1. **Know your core values**

2. **Work to find common ground**

3. **Unleash the power of true partnerships**

“The future can look better when you break from the same old same old.”

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