



Review & Commentary on Health Policy Issues for a Rural Perspective – October 1st, 2006

Rural Jobs Need New Rural Health Strategy

The following is a periodic “Eye on Health” update about Wisconsin’s Strong Rural Community Initiative (SRCI), sponsored by the Wisconsin Department of Commerce’s Rural Health Development Council. SRCI is working to improve health indicators for selected rural communities in Wisconsin and to make collaboration for prevention the norm for rural communities statewide, not the exception. SRCI projects are based on a community collaboration, that at a minimum, include three sectors: governmental public health, medicine and business. This update shares initial impressions taken from an intensive literature review by a University of Wisconsin graduate student working with SRCI, Stacey Lindenau.

Health Affairs is the number one cited health policy journal devoted to publishing original, peer-reviewed research and commentary, widely considered a “must-read” by all those working to improve our country’s health status and reduce healthcare costs. So the fact that the July/August edition of *Health Affairs* affirmed the underlying principles for the recently launched Strong Rural Communities Initiative (SRCI) is well worth noting.

Three articles specifically address concepts key to and championed by SRCI. Georges Benjamin’s “Putting the Public in Public Health: New Approaches”

speaks to a need to draw broader involvement to attain population wide health improvement, namely that “the public, the business community and public policymakers” are essential components for healthy communities. Michael McGinnis’ “Can Public Health and Medicine Partner in the Public Interest” chronicles the history of animosity between governmental public health and private practitioners. McGinnis not only offers suggestions for breaking down these barriers but also elucidates the benefits of this public-private emphasis. Finally, the Paul Simon and Jonathan Fielding in “Public Health and Business: A Partnership That Makes Cents” masterfully explore the necessary but often overlooked role of local business as a partner for community health improvement initiatives. Fielding has been working on business’ role in community health since the seventies and has numerous articles which directly address the link between worker health, productivity and economic benefit.

SRCI projects concentrate on those variables of the health economic equation that individuals in local communities can control. While SRCI very much supports the need to “supply” local rural health care, its particular focus is on the “demand” side, aimed at reducing the need for healthcare services in the first place. Developing preventive health interventions that are easily adopted at the local level, rural communities are empowered to directly affect their health indicators and demand for care without waiting for major, external system reform. SRCI believes that rural residents and busi-



nesses can engage in and sustain healthy lifestyle choices; that health status can be significantly improved and that the rate of healthcare cost inflation can be reduced. Equally important, the consequent increase in employee productivity will allow local employers to be more competitive and to help retain/grow local jobs.

SRCI's six local communities have launched collaborative projects intended to reduce lifestyle related chronic disease. Most of these projects focus on worksite-based wellness programs as well as a "spill-over into" the broader community. This reflects the belief of SRCI's sponsor, Wisconsin's Rural Health Development Council (RHDC), that rural businesses provide community-wide leadership and through protecting the health of their workforces, can significantly impact their individual business vitality and strengthen local economies.

As participating local communities begin launching their programs, the RHDC is also beginning to address a number of public and private policy questions. How can public, private and voluntary sectors most effectively promote the need for collaboration among rural medical, public health and business partners to increase access to preventive health services? What evidence supports our hypotheses that collaborations serve to benefit rural community economic development through improvements in population health indicators? How will participating partners realize benefits from active participation in sus-

tained collaborations? What are the best practices for rural collaboratives concentrating on preventive health services? What are the advantages and disadvantages rural communities face, compared to urban communities when developing these multi-sector collaborative approaches?

There is a rich body of literature related to the above questions that can inform RHDC policy development over the next couple of years; below is a synthesis of what has been learned to date:

People are aware of what needs to be done, why it should be done and how it should be done but in general, they are not doing it. The benefit and need of preventive health practices have been studied and publicized since national prevention campaigns of the early 50s. The idea and importance of collaboration as an effective tool to improve broad community buy in and optimize resources has become common place after over 30 years of promotion. However, this knowledge is not often acted upon. The question is then, "why"?

Even when individuals do obtain the necessary information, many are either unwilling or unable to act upon it. Those organizations fortunate enough to actually implement evidence-based programs often find themselves short on funding. ("Evidence-based" prevention programming tends to involve theoretically sound but costly intervention designs.) As many communities know, prevention programming produces long-term results whereas funding cycles are characteristically short term and results based. This mix match furthers community's challenges in appropriating sustainable funds, thus many prevention program initiatives have dissolved before the results are in. The same holds true for collaboration efforts themselves. Such efforts tend to loose funding long before desired goals are met. Thus leaving preventive health initiatives without the leadership they need to thrive.

For those still searching for information there are more than enough resources. Lists of best practices, methods for collaboration formation and evaluation, lists of characteristics necessary for collaboration success and those characteristics which inevitably lead to failure are all readily available to even the

The **Rural Wisconsin Health Cooperative (RWHC)** was begun in 1979 as a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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novice community planner. Though large amounts of resources are a positive benefit, the affects can be negative. The sheer quantities and formality of available resources along with predominantly web-based points of access make these resources difficult to navigate for even the most adept researcher let alone members of the general public. Any community based effort could easily sink under the weight of requirements for or direction of “best practices” and/or “evidence” before any intervention has even been launched.

It is hoped that the experience from SRCI participating communities along with a commitment to include the business community and a new awareness about the non-sustainability of current health cost trends will produce real time, rural specific information from which actions to overcome these challenges can be identified. The SRCI community models and the accompanying statewide supportive collaborative leadership together provide the structure, manpower, and tools necessary to make a difference, both locally and statewide.

Most research to date leaves out the critical role of the business community. Simon and Fielding’s work is the exception. The continuing focus on collaboration tends to be limited to governmental public health, small rural hospitals or academic outreach. Though calling for community-wide involvement, most studies involve limited partnerships instead of developing broad based, sustainable collaborations. “Community wide” needs to be more than a catch phrase, it needs to be a dynamic concept crossing *multiple* sectors of the community: namely faith based organizations, civic organizations, professional organizations, private medical providers, governmental public health services, health care networks, local hospitals and area businesses.

Small, locally owned businesses are often the heart and soul of rural communities yet they are seldom actively included in community health improvement efforts. Few examples were found which include businesses as a necessary component of community collaborations. And these tend not to be found in professional publications but on research center and/or foundation websites.

Even though the much acclaimed national initiative “Turning Point” attempted to recast “public health” as a broad based, multi-sector, community-wide concept relating to the health of the public, “public health” continues to be more alienating than assimilating for many outside of governmental public health. Use of the term “public health” continues to be a point of confusion. Qualifiers should be used to enhance inter-disciplinary understanding. Specifically, “governmental public health” makes clear the reference to any government supported service and or department. Alternatively, terms like “healthy people”, “healthy communities”, “community health”, and “population health” more easily refer to the health of large groups of people served by diverse combinations of health service providers.

There is ample discussion on both the economic and health benefits of preventive health programming, especially worksite wellness applications, but again adoption is weak. The need for and value of preventive health measures began in the 1950s when population health indicators began to show a rise in largely preventable chronic diseases. As early as the 1960s, field research on the effectiveness of prevention programs had already been initiated. By the early 1970s, limited case study results produced sufficient evidence to encourage some of the nation’s largest employers to invest in worksite wellness programs aimed primarily at individual risk factors. Variation in prevention delivery methods began to unfold in the 1980s followed by an expansion in formal analysis and creation of corporation—academia collaborations to empower long-term studies in the 90s.

Since then the proportion of American firms offering some form of preventive health services has risen drastically. Today, “over 80% of worksites with 50 or more employees offer [preventive health] programs. Large employers, those with 750 employees or more, almost universally offer resources aimed at improving worker health.” (Reidel, Lynch, et al authors, “The Effect of Disease Prevention and Health Promotion on Workplace Productivity”, January 2001, Vol. 15, No. 3, *American Journal of Public Health*.)

Most research lauds the benefits of prevention and worksite wellness to medium or large scale employ-

ers even though 99% of all companies with employees are small businesses. These small businesses employ close to 50% of all private sector US employees thereby providing 45% of all US payroll dollars. Rural areas disperse a larger proportion of their payroll dollars through small employers. A fact which makes it all the more discouraging that such a small sub-section of peer reviewed literature mentions the role of small business.

Effective multi-sector policy development efforts to enhance preventive services and knowledge uptake are still very limited. As a society, America is well educated on health and fitness. What to do, the consequences of action and inaction are well known. Even so, preventive health and healthy lifestyle choices are still not widespread enough to turn our nation's population health indicators around. The obvious question is "why"? With a plethora of information and copious evidence, why are these half century old revelations still not widely realized in our society? Almost all researchers mention the need for policy in support of preventive services and collaboration, or both, though few make concrete policy recommendations. It appears that part of the problem lies within the word itself.

"Policy" is a word that can unnecessarily confuse and alienate. Authors dodge a direct treatment of it and communities shy from it in large part because of the political images it conjures. However, when viewed simply as "the rules we play by" or what the community considers "normal" behavior, it can be a very powerful tool in the hands of community leaders.

Policies do not have to be formal statutes, regulations, or tax levies. Policies can be as simple as organizational guidelines of conduct. Staff meeting refreshments can be fresh water and bran muffins instead of coffee and doughnuts, after hours work sessions can feature salad instead of pizza, and ten minute "stretch and move" breaks can be periodically slipped into long meeting schedules, all of these are examples of organizational policy change in action. More formal "policy" can be found between community members and their local school board members with the

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Information at <http://nrharural.org/>

agreement that local schools supply at least two servings of fresh fruit and/or vegetables per day. Recommendations should therefore assist in breaking down the perception

of policy reform as being out of reach and highly political, thus enabling small communities to launch and sustain preventive health efforts.

One key goal of SRCI is to make real time, sustainable differences in rural communities. Participating communities and their statewide leadership strongly encourage dialogue and debate around these efforts and findings. Open dialogue allows for "real time" sharing of our "lessons learned" as well as the spark to ignite an invigorating debate on the use of collaboration to empower communities—empowerment for communities to accept ownership of their own health status and create and sustain collaborative models of preventive health services designed to improve population level health indicators. Accordingly, feedback is welcome on this commentary to SRCI via stacey-lindenau@aol.com or timsie@rwhc.com.

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Risk Factors Drive County Life Expectancy

From "How long you live depends on which USA you live in" by Steve Sternberg in *USA TODAY*, 9/12/06:

"America is a nation divided by vast differences in life expectancy, a 'longevity gap' that can't be readily explained by race, income or access to health care."

"In fact, when viewed through the prism of life expectancy, there are eight Americas, with decades separating groups consisting of millions of people, report Harvard's Christopher Murray and his colleagues."

“His team examined state and county life expectancies, the risk of death from specific diseases, health insurance and access to health care for major population groups from 1980 to 2001. They found that life expectancy differences are driven mainly by chronic diseases in young and middle-aged adults. Income, infant mortality, violence and HIV/AIDS, which now responds to drugs, played less of a role.”

“Among long-lived people 15 to 44, the death toll from chronic disease was as low as among the Japanese. The profile for the group with the shortest life span resembles Russia. ‘Where we fall down is delivering health care for young and middle-aged adults,’ Murray says.”

“The longest living group, ‘America One,’ consists of 10.4 million Asians, with an average life expectancy of 85, says the study in the journal *PloS Medicine*. That’s 27 years longer than the average 58-year life expectancy of Native Americans in South Dakota.”

“The second group, ‘America Two,’ indicates that income isn’t the key to a longer life span. This group is made up of 3.6 million low-income whites living in Minnesota, the Dakotas, Iowa, Montana and Nebraska, with an average life expectancy of 79. ‘White populations living below the median incomes in northern states have the best level of health among whites. That runs counter to everything we know,’ Murray says.”

“The 214 million people in ‘America Three,’ the bulk of the population, have an average life expectancy of 78. Next, in rank order, come poor whites in Appalachia and the Mississippi Valley

The Eight Americas

1. Asians – Average Life Expectancy (ALE) of 85 years
2. Northland low income rural white – ALE = 79 years
3. Middle America – ALE = 78 years
4. Low income whites in Appalachia and the Mississippi Valley – ALE = 75 years
5. Western Native Americans – ALE = 73 years
6. Black middle Americans – ALE = 73 years
7. Southern low-income rural black – ALE = 71 years
8. High-risk urban blacks – ALE = 71 years

with an average life expectancy of 75, Western Native Americans, who live to an average of 73, and black middle America, also 73. Low-income Southern rural blacks and high-risk urban blacks, ‘Americas Seven and Eight,’ live to 71.”

“Jonathan Skinner of Dartmouth says much of the variation depends on such individual factors as diet,

exercise and smoking, not health care. ‘Yet we spend much of our attention and 16% of our national income on health care,’ Skinner says. ‘There’s no way that differences in the quality of health care can explain 20-year gaps in life expectancy.’ ”

The original article describing the research noted in USA Today and many other news outlets can be found at < <http://medicine.plosjournals.org/> >. All material published by the Public Library of Science, whether submitted to or created by PLoS, is published under an open access license that allows unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

The Conclusion in the study as published by PLoS was more to the point than much of the media’s spin:

“Disparities in mortality across the eight Americas, each consisting of millions or tens of millions of Americans, are enormous by all international standards. The observed disparities in life expectancy cannot be explained by race, income, or basic health-care access and utilization alone. Because policies aimed at reducing fundamental socioeconomic inequalities are currently practically absent in the US, health disparities will have to be at least partly addressed through public health strategies that reduce risk factors for chronic diseases and injuries.”

RWHC Eye On Health



“Eight Americas seem like seven too many.”

A New Story in the Rio Grande Valley

This editorial is by Thomas D. Rowley, a Fellow at the Rural Policy Research Institute; his columns can be found at < <http://www.rupri.org/editorial> >.

“In a valley that isn’t a valley, perception not only trumps reality, it can alter it. For decades, the dominant perception of the pancake-flat southern tip of Texas—dubbed the Magic Valley of the Rio Grande by hype-happy land marketers—has been one of despair. Little income. Little opportunity. Little reason to hope. Reality followed suit. At the Llano Grande Center for Research and Development (llanogrande.org), however, area high school students are changing both. On a visit to the center, I began to see how.”

“ ‘Most objective indicators,’ says Francisco Guajardo, Llano Grande’s founder and director, ‘suggest that we are impoverished; but we cannot obey the pitiful indicators. We would waddle in misery if we did that. We choose to take a radically different approach, where kids gain so much power that the world is their laboratory...where kids believe that they can change the world.’ ”

“And they are. Some students created an informational campaign that swayed voters to pass a \$21 million bond issue for new schools. Others helped convince the state legislature to allow undocumented students to pay in-state, rather than international, tuition rates at state universities. Others established a youth advisory council to champion local park improvements. Still others host candidate forums. The list goes on and on.”

“And so do the students. They go all over the country and the world on student exchanges and internships—part of what Guajardo calls breaking the ‘isolation that really controls a lot of rural places.’ And they go to college. According to Juan Ozuna, a Llano Grande alum and one of its program directors, the percentage of local kids going to college has doubled, going from 30 to 60 percent. And they’re going not just to regional or even state schools; they’re going to the Ivy League—70 kids in the last 8 years. Ozuna

himself graduated from Yale. And then, like so many others before and after him, Ozuna came back to the valley to help others.”

“All of this from kids in a region that year after year ranks among the poorest in the nation.”

“Yet Guajardo doesn’t see the students’ success as achievement in spite of their economic situation. Rather, he says their success is because of their situation. Economic need translates into the drive to achieve for one’s self and for others. Family, community and culture translate into strengths upon which to build.”

“ ‘We’re really tired of people feeling sorry for themselves,’ says Guajardo. ‘Just about every signal tells them that they’re not all that. Well, we beg to differ... Our approach is a distinctly assets-based approach. We work on identifying, building and celebrating the assets of people. We are revolting against the deficit paradigm.’ ”

“Edyael Casaperalta, who as a child came with her mother and younger sister from Mexico one night and is now a graduate student at Ohio University, puts it this way: ‘In our communities, too many times we’ve been told that we can’t. And we internalize that... We’re doing away with the stereotypes and the limits that have been put on our imaginations that have [held us down] and kept us colonized.’ ”

“And with a line that I heard again and again at Llano Grande, she sums it up: ‘We can write our own story.’ The way students of Llano Grande write their own story is somewhat complex, but then as Guajardo points out, ‘Communities are complex; people are complex.’ The work involves everything from developing and delivering classroom curriculum (the center was born in the local high school) to cultivating leadership activities to helping train students from all across the country in such things as digital storytelling.”

“ ‘People ask what we do. It’s hard to describe,’ says Delia Perez, another program director and Llano Grande’s first Ivy Leaguer. ‘I can give them a list of services and that may satisfy them, but I wouldn’t be satisfied with it.’ ”

“Nor would 17-year-old Nadia Casaperalta, a self-described at-risk student who nevertheless was instrumental in the park efforts and the candidate forums and will soon head off to Kalamazoo College in Michigan. ‘I really can’t describe it. It’s really more than family...and I think that’s what makes our organization so powerful.’ “

Rural Will Exceed Rising Expectations

by Tim Size, RWHC Executive Director

When you talk about the quality of rural health care, the most important work to date is the Institute of Medicine’s 2005 Report, *Quality Through Collaboration, the Future of Rural Health*. It states that rural communities are assumed to have the same quality challenge as urban communities. Although the evidence specific to rural hospitals is limited, what there is supports the general finding for all hospitals, “that the level of quality falls far short of what it should be.” In other words, the quality of American healthcare needs to significantly improve and the quality of care at hospitals in rural communities has not been shown to be better or worse than the quality of care provided in urban hospitals. Two members of the Committee went on to emphasize these key points:

“Most quality initiatives in the United States have been developed with urban health care in mind and have not always been applicable to rural health care settings” *Mary Wakefield, chair of the committee that wrote the Institute of Medicine’s rural report.*

“Rural hospitals that survive will be those that demonstrate they are able to provide good quality care.”
Ira Moscovice, Director, Rural Health Research Center, University of Minnesota.

Bill Sexton, President of the National Rural Health Association, during his keynote at Wisconsin’s rural health conference this year, reminded us that rural hospitals can demonstrate excellence. He quoted extensively from an independent study of hospitals in the state of Washington that looked at readmission rates for several common surgical procedures, an important quality indicator. Bottom line: hospitals in rural communities typically had comparable to better rates than their urban counterparts.

Closer to home, rural hospital performance looks good on CheckPoint, the Wisconsin Hospital Association’s public reporting program for quality and error prevention measures. Scores are available on the CheckPoint website for 14 Medical Services quality indicators for those rural hospitals with sufficient data to be “statistically relevant.” The average score of these rural Wisconsin hospitals was as good or better

than the national average for all hospitals, urban and rural, on 12 of the 14 measures. It is agreed that all hospitals need to be better, but this is evidence that rural hospitals are not lagging behind.

Participants in RWHC’s Quality Coordinators Roundtable were asked last summer, “what would you advise a colleague if you were asked what were the most important quality initiatives for a rural hospital?” They shared generously and demonstrated the straightforward common sense characteristic of so many people working in rural health.

RWHC Eye On Health



“It is easier to beat low expectations due to someone’s bias, than to get credit for doing it.”

The Quality Coordinators emphasized making data collection and feedback to hospital staff a priority; to collect data on patient care processes and outcomes and continually report in a format that is easy to read. They promoted working to improve performance on Joint Commission on Accreditation of Healthcare Organizations’ core measures for congestive heart failure, acute myocardial infarction and community acquired pneumonia as well as to improve performance on the Joint Commission’s National Patient Safety Goals. They focused on changing care systems

such as requiring site marking, implementing barcode scanning for medication administration and developing care pathways to deliver more consistent higher quality of care. Perhaps most importantly they talked about assuring a hospital work culture that is non-punitive, focuses on teamwork and is organized into small quality action teams.

An initiative by RWHC hospitals over fifteen years ago led to the development of the RWHC Quality Indicators Program, now providing data collection and management for more than 100 facilities representing over twenty states. It is one of two rural-based performance measurement systems on the Joint Commission's list of acceptable systems. Participants include both Critical Access Hospitals and Prospective Payment Hospitals. Regardless of the organization's status, participation is clearly based on the ability of the RWHC Quality Indicators Program to provide easy access to facility-specific data that is relevant for both quality improvement and benchmarking.



We have entered a period of expanding public reporting with too many groups with differing reports claiming to speak for what the public needs to know. But this will settle down into a more uniform and consistent set of expectations for all

hospitals, including hospitals located in rural communities. In the meantime it is critical that at least some measures begin to reflect the real context of rural health. Ira Moscovice and colleagues at the University of Minnesota have taken up this challenge and are, with major input from the field, developing "quality measures for core rural hospital functions such as triage, stabilization and transfer, emergency care and integration of care with other local providers which are not considered in existing quality measurement sets."

Mary Wakefield sums it up best: "capitalizing on their unique strengths, rural communities and health care systems can meet the expectations associated with delivering the highest quality of care possible."

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