

Managing Partnerships: The Perspective of a Rural Hospital Cooperative

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Preface

While a dairy cooperative provided the bylaws, managing a cooperative of rural hospitals has been a learn as you go experience. This paper presents the management principles that have been learned over the last thirteen years. Their experience suggests that developing and managing partnerships requires behaviors different from those typically associated with the management of individual organizations.

Special thanks to Rural Wisconsin Hospital Cooperative hospitals and staff who continue after thirteen years to still teach me about cooperative leadership and to the Robert Wood Johnson and W. K. Kellogg Foundations who have made significant investments in our development.

Introduction

Cooperatives, alliances, coalitions, consortia, networks -- there are a variety of names for health care providers seeking collaborative approaches to common challenges, developing partnerships. While cooperatives of health care providers by any name are becoming more common, we still don't know much about how they are most effectively managed. This paper presents the experience of one rural hospital cooperative over the last thirteen years.

While it is unlikely that something as complex as the development of even one multi-organizational partnership can be reduced to single set of principles, the author believes that this paper is a reasonable summary of what has worked for management of this cooperative. While not the focus of this article, the author's experience with developing partnerships between the cooperative and other associations, a university and a state government leads him to believe that these principles do have a broader applicability. It is left to the reader to judge how applicable these ideas are to his or her work.

Brief Description of the Rural Wisconsin Hospital Cooperative

The purpose of the Rural Wisconsin Hospital Cooperative (RWHC) was and is to act as a catalyst for regional collaboration. Since its incorporation in 1979, it has tried to be an aggressive and creative force on behalf of rural health care. It has become nationally recognized as one of the country's earliest and more successful models for networking among rural hospitals. By actively

sharing RWHC's experience and ideas, it has contributed to the implementation of similar efforts around the country. RWHC employs or contracts for the services of approximately 150 people (full and part-time) and has an annual budget of close to four million dollars, exclusive of affiliated corporations.

RWHC developed and provided the early administration of HMO OF WISCONSIN, one of the first rural based HMOs in the country, currently with over 40,000 members and operating on a consistently profitable basis. It developed and administered a Trust for indemnity health and dental insurance, which saved members over \$360,000 in its first year alone and continued until recently as a dual choice option for RWHC Hospitals. With private investors and operators, the Cooperative implemented a Mobile CT and Nuclear Medicine Services to rural hospitals, reducing cost and improving access to this service for RWHC members and other area hospitals. It has established a pilot loan guarantee program for RWHC hospitals in cooperation with the Robert Wood Johnson Foundation and the Wisconsin Health and Education Facilities Authority.

RWHC staff provide some services directly in areas such as: advocacy, audiology, multi-hospital benchmarking (related to hospital specific Total Quality Improvement initiatives), grantsmanship, occupational therapy, physical therapy, physician credentialing and privileging, respiratory therapy, speech pathology and ongoing rural specific continuing education opportunities.

RWHC has negotiated special group contract arrangements for members to obtain high quality consultant services in areas such as: computer software services, legal services, personnel services, market research, patient discharge studies and consultant pathologist services. A hybrid between the two approaches of hiring staff or contracting for services is the Cooperative's regional program managed by RWHC staff to recruit and schedule physicians as independent contractors for the majority of RWHC hospital emergency rooms.

A particularly productive and popular RWHC activity has been Professional Roundtables that regularly bring together RWHC hospital staff of the same discipline for mutual sharing and problem solving, continuing education and advising the RWHC Board and staff on program and policy development. This has been recognized as one of the primary benefits of RWHC -- learning from each other. The number of these roundtable groups that are active has significantly increased and now includes 22 professional or managerial groups (i.e. lab, pharmacy, radiology, etc.).

The Cooperative began as the result of informal discussions among several hospital administrators in southern Wisconsin. The model of the dairy cooperative was chosen because it respected the autonomy of the sponsors and was a type of organization familiar to the community boards that would have to approve individual hospital participation. RWHC has been repeatedly studied as a national model for networking among rural providers, including several Federal agencies: the Federal Office of Technology Assessment, the US. General Accounting Office and the Office of the Secretary of Health and Social Service.

RWHC is governed by a Board of Directors consisting of one representative (usually the hospital administrator) from each RWHC hospital. Each RWHC hospital has one vote on the Board of

Directors. While a consensus is usually sought, it is not required or always possible. The Board meets monthly, except in relatively unusual situations where the agenda is too light to justify a meeting. An Executive Committee is empowered to act on behalf of the Board between regular meetings and performs the functions of planning and personnel committees. A Finance Committee is responsible for setting and evaluating financial goals and performance. Ad-hoc Committees are created as needed for specific time-limited functions. RWHC is now connected to the HMO of Wisconsin through an interlocking Board of Directors and informal staff liaisons.

RWHC hospitals have two distinct roles in decision-making related to Cooperative activities. As a Director of RWHC, decisions are (usually) made from the perspective of what is best for the Cooperative. As a hospital administrator, decisions about participation in a RWHC program are made from the hospital's individual perspective that includes the judgment of the hospital board, medical staff and other local parties. Services provided to RWHC hospitals are based on written contracts between each participating hospital and RWHC. Apart from limitations within some of these contracts, RWHC hospitals are not required to buy services solely through RWHC.

A Framework for Describing the RWHC Management Experience

This paper makes the following assumptions:

Significant management practices necessary for successful cooperatives are not commonly seen in traditional vertically organized institutions and systems.

Most administrators have had little experience and even less training regarding leadership within the context of collaborative models.

The "natural" administrative response will frequently come out of traditions that may be inconsistent with the actions needed to support networking.

Cooperative development can look deceptively easy but collaborative processes sometimes require more time up front than that needed in authoritarian models.

Enlightened self-interest is necessary for organizations to work together.

The question of why consortia form was addressed by Howard Zuckerman and Thomas D'Aunno in a 1990 article on hospital alliances. "Organizations often cannot generate internally all of the necessary resources or functions; therefore, they enter into exchange relationships with other elements in the environment."¹ But providers can choose among a number of alternatives, why networking? Zuckerman and D'Aunno believe that the ability to maintain local autonomy while increasing their power as part of a group is a major attraction of consortia. While some work has been begun on developing a taxonomy for multi-hospital arrangements and collecting descriptive data about existing consortia, more work is needed in both these areas. Beyond that, those of us who work trying to develop and administer consortia are just beginning to learn what approaches are most effective.

James M. Carman, Director of the Graduate Program in Health Services Management at the University of California, Berkeley has written a yet to be published paper on strategic alliances among rural hospitals and other providers that in part begins to address the issue of alliance management and governance. It is hoped that more of academe will begin to investigate and describe the administrative and leadership principles that are most consistent with the successful development of consortia.

Riane Eisler in *THE CHALICE & THE BLADE, Our History, Our Future* describes two basic models used throughout history for organizing human relationships: a dominator model emphasizing the vertical ranking of individuals and organizations and a partnership model emphasizing horizontal linkages.² While both are ancient alternatives, the current development of practical partnership models in health care is still seen as innovative.

Cooperatives are abstractions, paper entities that are made up of other abstract corporate entities that are lifeless without the work of many people. The productivity of both local organizations and cooperatives are in large measure dependent upon meeting the needs of these individuals. Models of collaborative intra organizational relationships are a good source of models for inter organizational relationships as in both cases the outcome depends on the effective motivation of individuals.

Max DePree, chairman of Herman Miller, Inc. and author of *Leadership is an Art* offers a model for employer to employee relationships based on his experience that productivity is maximized by designing work to meet basic employee needs. His vision of the art of corporate leadership is bringing employees into the heart and soul of the organization. DePree's experience is primarily within the world of the Fortune 500, but he provides a useful framework for non-profit and public sectors. He describes eight fundamental interdependent conditions that workers need to have met within a company if the company is to be effective.³ They are used here to organize the principles found or "invented" over the author's thirteen year experience managing a rural hospital network.

Even though DePree is acknowledged as a strong and successful businessman, a cynical "real-worlder" may dismiss him as a "dreamer," notwithstanding his business success. Robert Greenleaf in *Servant Leadership* presents a pragmatic suggestion that may be helpful in thinking through the tension that DePree's principles can inspire. "For optimal performance, a large institution needs administration for order and consistency, and leadership so as to mitigate the effects of administration on initiative and creativity and to build team effort to give these qualities extraordinary encouragement."⁴ Rosabeth Moss Kanter in *When Giants Learn To Dance* offers a similar vision of the future for corporate America. "The years ahead will be best of all for those who learn to balance dreams and discipline. The future will belong to those who embrace the potential of wider opportunities but recognize the realities of more constrained resources -- and find new solutions that permit doing more with less."⁵

Principle #1: There is Mutual Trust

Develop a relationship based primarily on mutual trust so that the cooperative is not limited to the minimum performance inherent in written agreements.

While responding to a rapidly changing market in 1984, the implementation in six months, "from scratch", of a rural based HMO in Wisconsin was only possible due to the prior existence of a basic level of trust among the key actors. RWHC has been able to recruit and retain top talent in a relatively small non-profit organization in large part by making the development of mutual trust a key part of its corporate culture. RWHC board/staff discussions are occasionally quite vigorous but staff has a reputation that they can be trusted to implement the board's final decision.

RWHC's Emergency Room Physician staffing program has worked well for a number of reasons that relate directly to the cooperative's commitment to developing mutual trust. The development of a network of physicians willing to work in this program and the development of an efficient central credentialing process are key components of the success of this program. Physicians, even resident physicians, know that they will be well treated by RWHC staff whether it be negotiating last minute schedule changes or recognizing birthdays. Hospitals have had faith in the ability of staff to develop a good system, cooperating with the need for more uniform credentialing forms and processes.

Contracts defines minimum performance and penalties for failure; they are limited by yesterday's knowledge and vision. In contrast, mutual trust assumes the potential of limitless performance and visions not yet fully formed. These relationships fill deep needs, enable work to have meaning and to be fulfilling. True mutual trust, however, is risky because it requires individuals to depend on others, to be vulnerable to their performance.

Rosabeth Moss Kanter characterizes "in-house" competition as usually counter-productive: "the minute people need anything at all from the efforts of others or share a future fate, cooperation has all the advantages." However, she is quick to add that while cooperation inside a group is the path to greater productivity, competition leads to higher performance when it is among unrelated organizations.⁶ The understanding of who shares a common future or dependency clearly becomes a critical issue when trying to develop cooperative relationships.

Participants within a successful cooperative, sharing a common future, can develop a higher than "average" trust for each other, because a tradition of successfully working together has developed. Even in an era of uncertainty, participants trust that they can continue to be successful, together again overcoming barriers in a way that is mutually advantageous, accomplishing more together than they can separately. When it can be developed, mutual trust provides a security well beyond contracts and the limitations of numerous but necessarily finite contractual provisions.

Trust among multiple health care providers and other organizations is absolutely necessary to the timely implementation of significant new RWHC ventures. It is a fragile element between organizations, constantly in need of regeneration as key individuals and circumstances change.

Initiatives that require the cooperation of many actors, whether individual or corporate, bog down if they require proof and underwriting every step along the way. Development of systems of any complexity requires collaboration, and collaboration requires trust.

Beyond legal contracts, there is a need to develop relationships based on a reasonable degree of trust that cooperative participants can do what is "right" if afforded the opportunity to do so. Relationships among multiple organizations are certainly equivalent in complexity to that found within any family; while many families rely on prior agreements regarding individual responsibilities and dispute resolution, this is not what makes a family "work." It is the commitment to each other and shared goals that transcends rules held by a magnet to the refrigerator door.

Cooperative Behaviors to Encourage

- Cooperative leaders/staff need to earn the trust of participants and then protect that reputation as the critical asset it is, both from real or perceived breaches.
- Actively work to build trust of the cooperative participants with each other.
- Recognize that earning trust takes time and has natural limits to how quickly it can be developed.
- Recognize that relationships within a cooperative do entail calculated risks and are more amorphous or messy than relationships built on control of one party over another.
- Be responsive to changing conditions and return whenever possible to the spirit rather than the letter of prior agreements.
- Periodically remind participants that the cooperative isn't there to police or be responsible for their local, internal actions.
- When staff don't agree or in the rare instance they can't as a matter of professional judgment implement a cooperative direction, they need to say so.
- Without fanfare, admit all significant mistakes as soon as they are discovered.
- Implement with expediency all cooperative decisions or ask for timely reconsideration if new information surfaces.
- In general, treat all participant specific information as confidential unless already in the public domain.

Behaviors to Discourage

- Never undermine or appear to undermine local participant employer-employee

relationships, however "right" you feel you are.

- Never launder participant or cooperative dirty linen in public or private.
- Never breach or permit the breach of confidentiality of any information given in confidence.
- Don't be quick to enforce your rights in a contract.

Principle #2: Commitment Makes Sense

Participants may join a cooperative to explore its potential; they remain only if they perceive that they are receiving a good return on their investment of time and money.

RWHC started with a shared service mission to which advocacy was quickly added. The Cooperative offers a broad array of shared services from which hospitals pick and choose according to their individual needs; on the other hand, support for the Cooperative's rural advocacy role is relatively more consistent. Commitments have been made and continued to be made to the Cooperative because they have been structured in a way that attempts to maximize the "fit" for each individual participant.

As health care reform gains momentum, the Cooperative as a whole has been forming partnerships with other organizations and networks. A notable example is the development of an alternative regulatory model for its member hospitals. Through prior political initiatives, a consensus had developed in Wisconsin that an alternative provider type called Rural Medical Centers should be available for diversified rural hospitals. However such reform demands significant State staff time to implement and a State budget deficit had become an implementation barrier. In response, the state hospital association and RWHC developed an alternative funding strategy. A consortium application was developed for a Federal Rural Transition Grant with two-thirds of the grant allocated for hospital specific diversification projects and one-third allocated as a sub-contract to the State in order to help finance the necessary rule redrafting. The state hospital association and RWHC receive no money from the grant but receive assistance with one of their major policy initiatives. Each member of the consortium became committed to the collaboration because attention was paid to constructing a win-win scenario for each participant.

While its not a new idea that most people want to do well, want to make a contribution, the recognition is less common that organizations can or should promote an environment where these commitments are willingly made. A fundamental choice for every cooperative is whether to try to build a network on subtle (or not so subtle) coercion or with participants given the opportunity to discover and develop their individual commitment. As our country's systems have become more complex, decisions are seen as more impersonal and less rational. Individuals and even individual communities have become in too many cases too small a portion of the larger picture for that larger picture to be seen by them as a coherent whole. Most people don't work for an abstraction, but for themselves and other people; the benefit must be made concrete.

Networks of rural hospitals that are on a scale that can be identified, known and “touched” allow for individual participants to understand how their commitment can make sense. In an analogous manner, cities once made sense to their inhabitants when they were networks of neighborhoods or communities; cities don't make sense and consequently don't work when they try or pretend to be a single community. It is the rare large, well financed health care system that can match the supportive cooperative environment potentially available in the more modest scale of local cooperative with strong leadership.

Cooperative Behaviors to Encourage

- Recognize that commitment to the cooperative will vary among participants, over time and across issues.
- Focus on the visionaries and that large middle group of participants that will go along with a good idea once its utility is reasonably shown.
- Structure a variety of opportunities for participants to discover and develop the particular set of commitments that makes the most sense for their unique situation.

Behaviors to Discourage

- Don't depend on past accomplishments to support future commitment; it must continuously be earned.
- Don't let the cooperative become impersonal as it grows, commitments are best understood face to face and tend to fail in the abstract.
- Listen to but don't be preoccupied by the nay-sayers, they will always be with us.

Principle #3: Participants Needed

Each organization must know that it is needed for the success of the cooperative.

RWHC has benefited from a good deal of recognition within the “industry” but has tended to take a low profile with respect to local public relations. When RWHC staff or Emergency Room physicians work at a rural hospital they are providing patient services on behalf of the hospital, not on behalf of the Cooperative; the success of RWHC is ultimately determined by the success of the participating hospitals. Staff intends to present every new program and each annual budget with the same energy and focus as if it was the first potential sale to a new client. It is considered by staff as a major mistake to ever take for granted the participation or commitment of any hospital. The RWHC communication budget is ample testimony to the RWHC belief in the importance of early and frequent communication and consultation. RWHC hospitals are involved in all stages of grantsmanship by staff beginning with idea generation and throughout the

application and project implementation process.

Much of the need for hospital participation is obvious and reflects the ongoing challenge to have group participation large enough to justify joint action. RWHC is developing a Wisconsin franchise for the Iowa based Patient Care Expert System (a computer-based resource for clinical nursing information and individualized planning of care). By individual hospitals making the effort to move forward together, multiple benefits are obtained: a group discount, local training sites, focused input into subsequent software modifications and franchise revenue from sales to non-RWHC hospitals. Even more to the point, this major innovation is not currently available to individual rural hospitals. This type of scenario is not unusual and regularly makes clear why each hospital's participation is necessary for the good of the whole.

RWHC hospitals need to know that their work and the work of their organization is critical to the success of the Cooperative; the cooperative must develop a culture that continually communicates that the maximum potential contribution from every participant is critical to the organization's success. RWHC hospitals and related organizations must know they are needed by the network as a whole. This contrasts sharply with the mixed messages frequently heard by RWHC communities, many of which have significant economic and social challenges. These mixed messages - we are here to help but you need to do it our way, can leave them and their organizations feeling confused and belittled. For example, some regional medical centers talk about not working to "takeover" rural health care, while proceeding to aggressively expand their market share at the expense of local access and services.

For health care providers in a network to be effective they must be given an unambiguous message that they are needed even while they are being asked to undertake significant change. All health care providers are a meaningful part of the nation's health care agenda and are a valuable resource, both individually and collectively, for the innovation of more cost effective and accessible health care. They need to know it.

Cooperative Behaviors to Encourage

- Develop a corporate culture in which the participants are the cooperative.
- Make it clear that the success of the cooperative is meaningless without the individual success of its participants.
- Serve the cooperative through the accomplishment of mutually agreed to goals and objectives.
- Make sure that all users of cooperative services know that as the "customer" they come first.
- Recognize and promote the use of the significant pool of knowledge and experience already available within the cooperative.

Behaviors to Discourage

- Never assume you know what participants need or think.
- Don't ask for the cooperative's guidance and then do what you want.
- Never use any one's "expert" status to try to force a cooperative decision.
- Minimize depersonalizing references to participants in the third person plural: "they, them or those people".
- Discourage cooperative meetings becoming dominated by particular individuals.
- Discourage competition between cooperative programs and individual participant's programs.

Principle #4: All Involved In Planning

The planning is interactive, with the plan for the cooperative being the result of, and feeding into, the plans of the individual participants.

One theatrical but powerful example of ignoring the need for local input and preferences involved the Cooperative within months of its incorporation in 1979. Two regional health planners, with the very best of intentions, were practically driven from the bare wood stage of Wisconsin's historic Al Ringling Theater after their presentation of a unilaterally developed plan for local consolidations and closures. The plan was not implemented and did not contribute to further discussion of how rural health care in southern Wisconsin could be improved. Since then, local Wisconsin communities, understanding the scarce resources they face, have restructured more hospital activity than were ever dreamed of by central health planners during their zenith.

While the staff of RWHC are respected as well informed and creative professionals, the Cooperative's planning process focuses on determining the preferences and needs of the participating hospitals. Both the annual work plan and budget are driven by how the hospitals perceive they can make the best use of the Cooperative as a regional resource to assist their own local ability to survive and prosper. The State of Wisconsin's support for the Rural Medical Center as an alternative model for rural hospitals in 1992 flows directly, if not at some length, from a single RWHC administrator's input into the annual RWHC planning process in 1988.

With funding from the Robert Wood Johnson Foundation, RWHC implemented cooperative benchmarking: the continuous comparison of the functions and processes of similar hospital and non-hospital departments in order to identify and implement best practices. This project started from the request by a RWHC administrator for relevant comparative standards amongst RWHC hospitals but became more process oriented as a RWHC staff member became aware early of the potential application of Total Quality Improvement methodology to health care. More recently hospital feedback has led to the shortening of the time for completing an individual benchmarking cycle as well as increasing the involvement of other effected departments within each

participating hospital. RWHC programs are not the result of central office direction nor of a single local hospital - they are the result of both, an interactive process amongst RWHC hospitals and staff.

Russell Ackoff, in *A Guide to Controlling Your Corporation's Future*, promotes the idea that by meaningfully including all parts of the organization in the planning process, by making the planning process interactive, all those who can effect the organization's outcome develop a vested interest in it's overall success.⁷

Opposition to central private or public initiatives is frequently belittled as irresponsible local preferences for service regardless of cost. If for a moment however the proposition could be entertained that people are not automatically "backward or ignorant" when they fight against centralizing initiatives, some local preferences might be discovered to be rational. From the perspective of a local provider, it is rational to oppose initiatives which certainly lose local services and employment while gaining only a trivial portion of the larger system's uncertain savings.

While desperate or weak organizations may have no option but to accept patronizing assistance within larger networks or submit to more explicit and bold direct takeovers, healthier communities with greater productive potential respond more favorably to an approach based on mutual respect and responsibility with an appropriate sharing of risk and benefit. Communities and health care organizations must have genuine involvement in the planning and implementation of decisions that affect them. Dr. Susan Jenkins from the University of Georgia's Cooperative Extension Service puts it all very succinctly when she says, "If you come out of a (traditional) central office but still have that corporate mind set, you're not networking."⁸

Cooperative Behaviors to Encourage

- Cooperative leaders and staff need to balance their personal vision with their responsibility to discover and implement the vision of the cooperative as a whole.
- Identify common opportunities and threats as threads to support united efforts.
- Work to facilitate cooperative programs consistent with local programs and vice versa; be aware of the variety of local situations facing individual cooperative participants.
- If you are based within a traditional organization, remember you need to "switch over" to a more interactive planning style when you're working with the cooperative.
- Consult regularly with the cooperative for ongoing "midcourse" corrections; every cooperative meeting is both a board meeting and a focus group of customers.
- Make sure that each time the cooperative meets it is doing so to make one or more significant decisions.

- Treat cooperative meetings as the important corporate meetings that they are.

Behaviors to Discourage

- Don't get "hung up" on administrative "rights" as the board of a cooperative is also its primary or only group of customers.
- Don't take a "vertical or authoritarian" mentality into your "horizontal or collaborative" relationships.
- Never say "yes" when you mean "no".
- Don't proceed until you have the critical mass of participants "on-board" and don't judge your success by whether or not you had 100% of those in the cooperative agree to participate.
- Don't forget to check for "false positive" approvals regarding new cooperative programs; they are a particular risk of "cooperative group think."

Principle #5: Big Picture Understood

Participants need to know where the network is headed and where they are going within the network.

RWHC has a motto of saying it early and saying it often - we are not particularly concerned about "over communicating". A number of RWHC's more significant initiatives such as the development of a loan guarantee program, various quality improvement projects and advocacy for major education reform within the University of Wisconsin's health professional schools are multi-year efforts. Such projects require the ongoing reminder of their significance to individual RWHC hospitals, notwithstanding their earlier participation in the planning processes that led to these projects.

Just as RWHC has begun to network more at the state level, it has been actively promoting the establishment of partnerships between rural hospitals and public health departments within each county. RWHC has taken the position that the nation's emerging health care reform movement will require rural hospitals to look beyond the individual patient to see the whole community as a "new patient". Simultaneously, it will require them to recognize and respect existing initiatives by a variety of important public health organizations. Typically, many of us in the acute care sector have limited our definition of health care to patient care and that generally means visiting with a specific individual, forming a diagnosis, prescribing treatment, providing or referring for treatment and follow up as appropriate. Successful outreach to a community requires similar activities in an expanded context of the community as "patient" with a more complex array of partners.

The experience that RWHC hospitals have had in developing partnerships with each other is now beginning to be expanded into other spheres. Two RWHC hospitals have been invited along with hospitals in New York City, Philadelphia and Phoenix to develop proposals for a national demonstration project to develop community partnerships in order to better serve people with low income; three other RWHC hospitals have begun to work with their county public health department without any external funding. Wisconsin's Rural Health Development Council has accepted the suggestion of RWHC to make collaborative community decision making a priority for the technical assistance it is willing to provide rural hospitals and communities.

While not a new metaphor, participants need to see the larger picture printed on the puzzle box, a vision of how the puzzle fits together, how they fit in. What is the cooperative's mission, strategy and how are they a part of it? Where is the cooperative headed and where are they headed within the organization? Each participant needs an opportunity to create a personal vision of their own future with respect to the cooperative.

Participants need to understand the "strategy and direction" of the network or government policy or of any other corporate power that can substantively effect their future; if a local organization's leadership does not have a reasonable understanding of its environment, its employees will be similarly in the dark. Without that understanding every one's work will be substantially impaired.

Cooperative Behaviors to Encourage

- Networking is in large measure information and communication - make sure this is an unequivocal strength for cooperative leaders and staff.
- Cooperative goals and objectives, once determined, need to be continually communicated - "say it early and say it often."
- Recognize and without judgment account for the various levels of knowledge among the participants - develop efficient communication devices to allow for significant variation in the degree of prior knowledge or experience.
- Work to get all stake-holders, not just the participants' formal representative, the opportunity to understand the cooperative's plan.
- Give participants enough information to know when and how to ask for more information - a middle ground between keeping participants in the dark or hiding the trees in the forest of a million pieces of paper.

Behaviors to Discourage

- Don't assume that individual participants are too busy to be interested in a particular issue; this may often be the case (but let participants do the screening).
- Don't surprise the cooperative with unexpected news, good or bad.

Principle #6: Participants Effect Their Own Future

The desire for local autonomy needs to be made to work for the cooperative through the promotion of collaborative solutions that enhance self interest.

When RWHC began operations, many observers were highly skeptical about whether or not it would last, let alone make any real contribution - that rural hospitals' traditional need for autonomy would prevent any meaningful joint activity. Certain initiatives such as the development of the capability for RWHC to manage some of its own hospitals have been seen as precluded in large part due to this issue of autonomy. Some shared services have been under subscribed as hospitals have chosen local options when at least from the perspective of RWHC staff, a cooperative approach offered a better service at a lower cost. Notwithstanding these problems, the history of RWHC has been one of steady movement forward as collaborative approaches have been designed that respect the autonomy of each hospital.

RWHC staff attempts to look at the half of the glass that is full; it does not see it as their job to manipulate RWHC hospitals to do what staff perceives as the "right" thing; they see their job as developing and maintaining significant alternatives that will be accepted and sustained by the RWHC hospitals. The desire is not to make the hospitals "dependent" upon the cooperative but demanding of it through the strength that they gain, in part from the cooperative.

It is particularly destructive to the human spirit, and body, to hold an individual or group responsible for an outcome in a stressful environment but depriving them of the authority and resources to act. Karasek and Tores have found that the right to have control over one's work effects more than personal dignity, that it is a significant risk factor for coronary heart disease. "The primary work-related risk factor appears to be a lack of control over how one meets the job's demands and how one uses one's skills."⁹ Unilateral externally imposed policies by a regional HMO or threatened cutbacks in the availability of visiting medical specialists are routine occurrences for rural providers, chipping away at their sense of being able to effect their own future.

Dr. Helen Grace, a senior staff member of the W. K. Kellogg Foundation speaks to this issue when she says that the Foundation "... assists communities in solving the problems which they define, according to solutions they propose. To make the best use of the available resources, staff members of the Kellogg Foundation seek to understand the problems facing communities around the world, and to work with these communities to clarify and prioritize their concerns and to identify first steps toward reaching doable answers."¹⁰

The importance of individualism in our culture is one of the great American myths - not that it isn't true but that it is so true that we fail to pay it much notice, encompassing our lives like water does a fish. While it is unlikely that such a powerful, culturally driven self-image can be hung on a hook outside the workplace door, many organizations seem to adopt that premise.

Cooperative Behaviors to Encourage

- The role of the staff is to facilitate rather than control cooperative board decisions.
- The cooperative board decides what are its decisions to make.
- Make it clear nothing happens to participants unless they want it to happen.
- Use a decision-making process based on consensus for decisions that directly affect all participants.
- Avoid framing any issue that directly affects individual participants in terms of a search for a cooperative-wide right or wrong answer; facilitate each participant determining what is the right or wrong answer for their situation.
- Remember that a vote on the cooperative board for the cooperative to proceed with a project is not the same as that participant agreeing to be part of that particular project.
- Emphasize that the success of many projects is largely dependent upon the participant assuming full responsibility for implementation of the participant's piece of the cooperative-wide program.

Behaviors to Discourage

- Don't set up situations where the cooperative judges or use judgmental language about a participant.
- Don't take on the responsibility of being a missionary to "save" each participant from the consequence of their own decisions.
- Don't ever take a participant's participation for granted either as a customer or as part of the governance process.
- Don't set up situations in which the cooperative or an individual participant feels pressure to move forward but hasn't had the opportunity to make an informed decision.

Principle #7: Accountability Up Front

Participants in the cooperative, including cooperative staff, must always know up front what the rules are and what is expected of them.

The Rural Wisconsin Hospital Cooperative has been fortunate to have been a very stable group of hospitals; excluding an unsuccessful experiment with Affiliate members and one merger, only

one member has withdrawn over a thirteen year period. Discussions at RWHC Board meetings are frequently comparable to user focus groups and equally valuable - staff and hospital participants know what is and what is not expected of them. The one member that withdrew, a rural referral center, did so as its undeclared interest in using RWHC as a vehicle to market its own services had not been satisfied. Participation in all Cooperative shared services requires a signed contract, not so much as to permit legal enforcement but to assure that all parties in the partnership have thought through up front the expectations of all of the participants.

RWHC has been equally fortunate in being able to attract high caliber personnel with minimum turnover, individuals who do more for less than they would in many less challenging jobs. In part this is because there is a tradition that even in a relatively unstable field, evaluation of individual performance is based on those elements of the job that the individual could personally effect and that individual contributions are recognized and rewarded to the degree possible.

The University of Wisconsin is one of the country's great land grant universities and as such it has a greater, not lesser, responsibility to work to meet Wisconsin's need for generalist physicians, nurses and physical therapists in underserved communities. The Cooperative has been asking that the University assume "co-ownership" with it and others to more effectively address the state's need for additional providers in both its rural and inter-city communities, that it works with us as a full partner. To that end and as a beginning point in the partnership, RWHC has advocated that the UW System should commit up front to saying how it will and to what extent it will adjust its production of health professionals in response to the state's need for providers in underserved communities while maintaining program quality.

The importance of accountability within a cooperative is based on the observation that individuals and cooperating organizations work best when they receive timely feedback and that this feedback is based on mutually agreed to expectations. To due otherwise is to generate hostility or withdrawal.

If instructions or rules that a RWHC hospital needs to follow are changed retroactively, there is the potential of a ripple effect within each hospital. A retroactive change to the hospital frequently translates into a retroactive change for individual hospital employees. While employee oriented organizations can frequently buffer employees from external capriciousness, there are limits. At a minimum, they can not diminish the damage done to an individual who has worked hard in one direction to find out that the results of her labor are now unimportant, unneeded. If that happens too often, RWHC hospitals and employees with options, will begin to exercise them.

Picture the image of people working together within a network or organization when mutual expectations are understood up front and respected, compared to the ambiguous and faceless environment of most public or private bureaucracies. The fundamental variable in most networks or organizations may not be the participants but the environment; most of us have experienced the power of our work to either inspire or to suffocate.

Cooperative Behaviors to Encourage

- Clearly define roles: who is responsible for what, who decides, who develops criteria, who gets to see cooperative data.
- Record in writing all agreements and expectations.
- Like all corporations, develop and utilize appropriate planning and budget documentation.
- Make the cooperative's verbal commitment its bond, particularly around "political" negotiations that have not or won't be reduced to writing.

Behaviors to Discourage

- Don't ever speak for or obligate the cooperative or individual participants without their prior consent.
- Don't let familiarity and a collaborative agenda create sloppy business habits when it comes to spelling out an agreement about who is responsible for what.

Principle # 8 Decisions Can Be Appealed

A clear non-threatening appeal mechanism is needed to insure individual rights against arbitrary actions.

The use of the cooperative strength of RWHC hospitals has been used to force an appeals process when faced with a potential breach of contract by a single large urban based HMO; individually few could have justified the necessary prolonged legal challenge to enforce the contract but through concerted joint "inquiry" into the legal options available, further legal action become unnecessary. A particularly attractive feature of a multi-hospital insurance program, the RWHC Trust, was the ability of the participating hospitals to have appeals about disputed claims judged by their peers familiar with their work setting rather than a distant bureaucracy limited to only its written rules.

A need for relief from arbitrary action can also happen even before a relationship is developed. Rural health care providers, however financially sound, are frequently "red-lined" or excluded from increasingly national and international capital markets - an arbitrary action from the point of view of a well run rural hospital. "Bond market looks askance at rural and small urban facilities that need cash; meanwhile, high powered institutions benefit from fat ratings, cheap rates."¹¹ As an initial response, RWHC has established a pilot loan guarantee program for RWHC hospitals in cooperation with the Robert Wood Johnson Foundation and the Wisconsin Health and Education Facilities Authority. Use of the pool is based on objective rural sensitive loan criteria applied by RWHC colleagues with a final determination by the state hospital bond authority. The pilot is initially financed by a \$500,000 low interest loan from the Robert Wood Johnson Foundation. RWJF support for this private sector pilot was used as an incentive for the State of Wisconsin to

invest \$500,000 for the same purpose. Lenders to those hospitals who are accepted by both Programs will have 50% of loans with a principle up to \$500,000 guaranteed in case of default: 10% through a hospital reserve fund, 20% by the State and 20% by RWHC.

Cooperative Behaviors to Encourage

- Make it easy for participants to express a reservation, concern or complaint.
- In the case of a dispute that is not being resolved to both parties satisfaction, the participant should always be informed how best to make an appeal to the cooperative as a whole.
- Remember that the participant's right to appeal to a peer is one of the distinctive and appealing characteristic of a cooperative.

Behaviors to Discourage

- Do not enforce your "rights" unilaterally or quickly against any participants however clear you believe your case to be.

Summary

Most major reform alternatives to the single payer Canadian approach require that private and public purchasers of health insurance or plans organize themselves cooperatively under a few regional brokers or "sponsors" to negotiate with newly organized regional networks of providers. As both sectors are more attuned to "competition" than the cooperation that will be required by such proposals, the experience of the Rural Wisconsin Hospital Cooperative and other networks is perhaps more timely than ever. There is a need for innovative inter organizational relationships that, in DePree's words, encourage participants "to do what is required of them in the most effective and humane way possible."¹² Success in health care requires new private, public cooperative attitudes, processes and structures built fundamentally upon an understanding and respect for real people working in local community based organizations.

¹ Zuckerman, H. S. and D'Aunno, T.A. "Hospital alliances: Cooperative strategy in a competitive environment." Health Care Management Review 15, no. 2 (1990): 21-30.

² Eisler, R. THE CHALICE & THE BLADE, Our History, Our Future, San Francisco: Harper, 1988: xvii.

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- ³ DePree, M. Leadership is an Art. New York: Doubleday, 1989.
- ⁴ Greenleaf, R. K. Servant Leadership. New York: Paulist Press, 1977: 60.
- ⁵ Kanter, R. M. When Giants Learn To Dance, New York: Simon & Schuster, 1990: 18.
- ⁶ Ibid: 75-78.
- ⁷ Ackoff, R. L. A Guide to Controlling Your Corporation's Future, New York: Wiley, 1984.
- ⁸ Personal conversation.
- ⁹ Karasek, R & Theorell, T. HEALTHY WORK, Stress, Productivity, and the Reconstruction of Working Life, New York: Basic Books, 1990: 9.
- ¹⁰ Grace, Helen K. "Building Community: A Conceptual Perspective" INTERNATIONAL JOURNAL OF THE W. K. KELLOGG FOUNDATION 1, no. 1 (1990): 20-22.
- ¹¹ Nemes, Judith "Hospital borrowers finding it tougher to scale the wall on Wall Street." Modern Healthcare 22, no. 25 (1992): 59.
- ¹² DePree, ibid: 1.