

Rural Wisconsin Hospitals Work Cooperatively to Maximize Community Controlled Services

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Although cooperative activities have long been familiar to residents of Wisconsin, a state that ranks second among states in its total number of member-owned cooperatives, a group of Wisconsin hospitals extended that tradition in 1979 to their own arena in an effort to maintain local control of community hospital services.

The Rural Wisconsin Hospital Cooperative (RWHC) provides shared services and political leverage for 11 members, including 10 rural hospitals and the University of Wisconsin Hospital in Madison. Each has one representative and one vote on the Co-ops board of directors.

While the University Hospital differs greatly from other RWHC members, its membership recognizes University-based assistance in the co-op's formation and its ongoing support through various University resources, including the hospital's Office of Regional Development.

Members of RWHC see its value as optimum on a regional rather than statewide basis. The 10 rural members, including one with facilities in two towns, are located in central and southern Wisconsin communities -- Baraboo, Boscobel, Cuba City, Dodgeville, Edgerton, Lancaster, Platteville, Prairie du Sac, Reedsburg and Stoughton.

In keeping with this perception, RWHC Executive Director Tim Size serves on various committees of the Wisconsin Hospital Association, an organization RWHC makes no pretense of supplanting, but to which the Co-op seeks to strengthen rural input. Size also represents the rural hospitals on the Health Planning Council (the Wisconsin Health Systems Agency) Board of Directors. Through these forums, other political testimony and widespread media coverage, RWHC has argued the importance of locally controlled hospital services in the midst of a nationwide trend toward multi-hospital systems' takeover of community hospitals.

Size last summer assessed the need to establish greater viability for community-controlled hospitals as a battle that takes place on two attitudinal fronts. First, many communities and health planners, confronted by increasingly complex riddles of financial problems, are inclined to view outside corporate management as a solution with a rather mystical power, a sort of "sex appeal, like a big car."

While multi-hospital systems are fast proving their ability to turn around the financial failure of small hospitals by drawing on corporate personnel and capital resources, members of RWHC believe the community pays heavily in loss of local control in developmental decisions and responsiveness to local conditions, as well as outflow of dollars from the local economy.

A second hazard to small community hospitals tends toward the opposite extreme of attitudes. "Resistance to multi-hospital management by community boards may cause them to wait too long, causing the hospital to go under," Size said.

In the milieu, RWHC is orchestrating a carefully planned effort to establish an alternative that recognizes both the value of multi-organizational resources and the importance of local decisionmaking. The Co-op presents itself not as a savior, but as a resource for assistance in the member hospital's individual efforts toward survival.

RWHC's program operates directly through its own staff, rather than through staff volunteered by member hospitals. Basic operating expenses are assessed equally to each member on an annual basis, currently at just under \$5000 per member. As RWHC membership grows, the cost per member will drop proportionally. Supported by these revenues, RWHC acts as an advocate on behalf of general member interests.

The remainder of RWHC's approximately \$500 thousand current-year budget stems from the Co-op's role as a broker on behalf of specific member interests. RWHC buys a particular service and resells it to only those members



(and sometimes non-members) who want it, as opposed to the entire membership. Shared services are priced to break even after all direct and indirect expenses are met.

RWHC operates recently expanded physical and respiratory therapy services, and has contracted to provide members with legal specialty, institutional planning, financial consultation, dietary and social work services. The Co-op has helped members acquire contracts for pathology services at greater frequency and cost-efficiency than available in the past. RWHC also provides graphic design, forms design, and printing services, and has just begun a shared public relations program.

One of RWHC's most progressive efforts involves negotiations with major health insurance carriers on a prepaid health plan that would supplant a particular company's current insurance plan in the RWHC region. RWHC board member Peter Preussing recently said several companies have expressed strong interest in the plan, which would include patient incentives to obtain health care within their localities, based on lower costs for provision of care in rural hospitals than in urban institutions. Because of the complexity of the issues involved, these negotiations will not be completed quickly, but Pruessing indicated that development of the plan is being approached very seriously by all parties.

The RWHC "Management Development Program," a two-year course in which 150 middle managers (including non-members) have enrolled, presents a good example of the thorough planning which precedes RWHC ventures.

RWHC surveyed its members, shortly after the Co-op developed out of an informal study group in 1979, to determine potential shared services of high interest. In-service and continuing education were among those identified, as were the other services listed above.

A task force used internal needs analyses to collectively design the 24-module course, which is similar in content to "the type normally available in large hospitals," according to Size. It essentially focuses on financial personnel, and self management through workbook exercises, case studies, and discussion.

The course, which will begin in January, is designed to reconcile minimal travel complications with substantial input from other hospitals. Study groups of 15-20 will work on an in-house basis with RWHC-trained faculty, meeting intermittently with other groups at sub-regional gatherings of about 40 persons. All 150 participants will meet together only once. This approach "has been extremely well received" by the hospitals, Size said.

The Co-op, which is appropriately based in a small building that was Sauk City's first hospital, hopes to add a half dozen new members in the coming months. RWHC wanted to establish its effectiveness before vigorously promoting membership, and Size believes they have done so at this point.

Size recently said he considers the Co-op's viability to be very good, but also expressed caution in predicting whether such an approach can successfully maintain local control indefinitely. "You cannot underestimate the multiple forces at work on small hospitals; this is not a period of subtle changes," he explained.

In Wisconsin, at least, a well-organized group of hospitals is striving to build an integrated and coordinated system within these economic pressures and their own pride in autonomy. They provide a strong model to those in other states who must grapple with the same harsh realities and the question of whether they will join someone else's system or create their own.