



Rural Wisconsin Primary Care Improvement Project

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RWHC's Mission and Vision

Vision (Future we want): Rural Wisconsin communities will be the healthiest in America.

Mission (How we do it): RWHC's mission is to be a strong and innovative cooperative of diversified rural hospitals; it intends...

... to develop and manage a variety of programs and services.

... to assist Members to offer high quality, cost effective healthcare.

... to assist Members to partner with others to make their communities healthier.

... to be the "rural advocate of choice" for its Members...

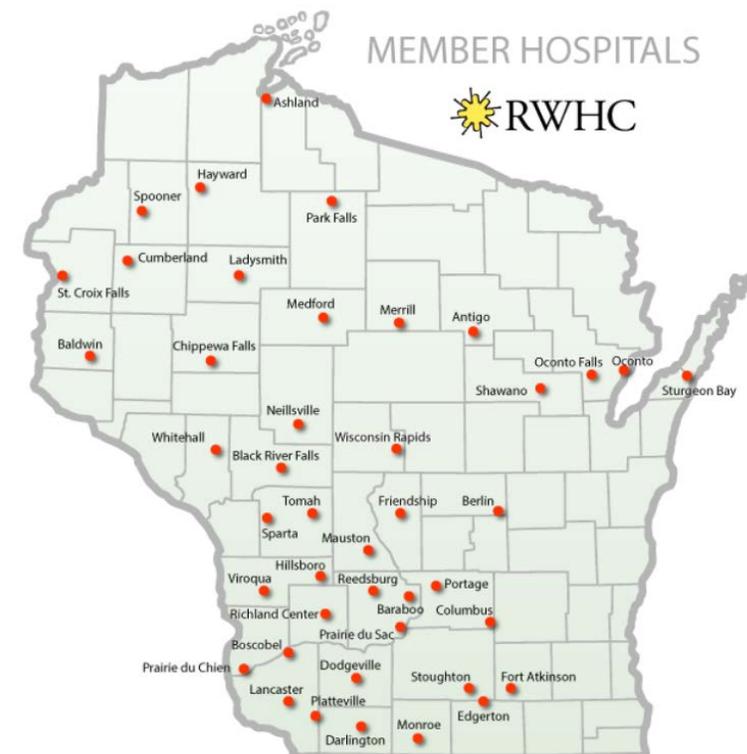
... to generate additional revenue by services to non-Members.

... to actively use strategic alliances in pursuit of its Vision.



RWHC at 10,000 Feet

- Founded in **1979** by rural hospital CEOs in several southwestern counties
- Non-profit cooperative of **43** rural healthcare organizations
 - Creating **\$3.6B** in economic activity
 - **25,000** community jobs
- **8 PPS** and **35 CAH** = 21 independent and 22 affiliated
- RWHC employs **70** employees
- RWHC Budget = **\$18 M**
 - 75% member services
 - 15% non-members
 - 6% dues
 - 4% grants





RWHC Primary Advocacy Issues

- Appropriate **Medicare/Medicaid** Funding/Regulation
- Local Care via Health Plan **Network Adequacy**
- Relevant **Volume to Value & Wellness** Incentives
- Avoiding Rural **Collateral Damage** as Giants Battle
- Focus on **Statewide Workforce Supply** & Distribution
- All **Caregivers Working Top of Education & Training**
- Focus on **Caregiver Engagement/Retention**
- Promote Rural **Economic & Community Growth**



Rural-focused Shared Services

- **RWHC *Educational* Services**
 - Professional Roundtables & Listservs, Nurse & Leadership Residencies,
 - Preceptor Workshops, Agency Staff & Student Orientation Portal
- **RWHC *Professional* Services**
 - Representing Members with Health Insurers, Legal Consultation,
 - Clinical Services, Medical Record Coding
- **RWHC *Quality* Programs**
 - Credentials Verification & Peer Review Services,
 - **Primary Care Programs**
 - Quality Indicators & Improvement Programs, Mystery Shoppers
- **RWHC *Technology* & Other Services**
 - Workers Compensation Captive Insurance Company, Data Protection,
 - Email Encryption, Information Tech Network



Roundtables

- Important collaboration and trust for foundation
- Input – member participation on what's important; discuss topical issues
- Develop – exchange ideas and implement special projects
- Advocacy
- Workforce shortage issues



Primary Care Project Development Background

- **2015** - Primary Care, Chronic Disease Management, and Merit-based Incentive Payment System (MIPS) identified as among RWHC member priorities through Navigating Payment Reform Initiative
- **Primary Care Workgroup** established to provide input on next steps
- **Primary Care Quality Roundtable** established to promote best practice sharing and provide MIPS education
- **HRSA Network Development Grant** applied for and received to drive improvements in HbA1c and Blood Pressure control



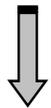
RWHC Primary Care Improvement Project

- **Network approach** to improving quality associated with diabetes and hypertensive disease care in rural primary care settings
- **10** RWHC members with **26** clinics and **100+** practitioners participating
- **Monthly Project Committee** meetings kicked off in August 2017
- **Primary Outcome Improvement Goals:**
 - ✓ Reduce the percentage of populations diabetic patients with HgbA1C poor control
 - ✓ Increase the percentage of the population's hypertensive patient with adequately controlled blood pressure

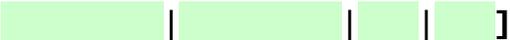
Expected to lead to reduced costs through decreased target population emergency room visits and inpatient admissions.



Evaluation Results Scorecard (October 2019)

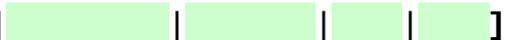
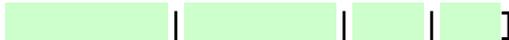
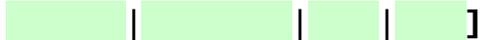


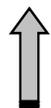
Reduce Uncontrolled HbA1C

- 1. **Lower % of target patients with uncontrolled HbA1C** [G = decreasing | A = | ]
Annually beginning with First program year [Data-Physician Compass] 1st and 2nd Program Years



Improve Blood Pressure Control, BMI Screening and Summary of Care Exchange

- 2. **Higher % of target patients with controlled BP** [G = increasing | A = | ]
Annually beginning with First program year [Data-Physician Compass] 1st and 2nd Program Years
- 3. **Higher % of target patients with BMI Screenings** [G = increasing | A = | ]
Annually beginning with First program year [Data-Physician Compass] 1st and 2nd Program Years
- 4. **Higher % of summary of care exchange** [G = increasing | A = | ]
Annually beginning with First program year [Data-Consortium Participants/LW] 2018 and 2019 surveys



Expand Improvements to Other Clinics and Organizations

- 5. **# of organizations participating in consortium** [G = 10%, increasing | A = | ]
Annually, beginning with Third program year [Data-LW] July 18 and October 19 data



Unique Collaborations

- **Physician Compass:** provides quality data/evaluation tools, MIPS compliance and submission to help members measure primary care quality improvement
- **Wisconsin Collaborative for Healthcare Quality (WCHQ):** helped develop the Rural Wisconsin Chronic Disease Toolkit
- **Wisconsin Hospital Association Information Center (WHAIC):** produced physician efficiency and quality reports using WHIO data, which provides ED and inpatient volume and readmission data
- **Wisconsin Office of Rural Health (WORH):** funding source for the education services
- **University of Wisconsin Research - Diabetic Foot Ulcer Project:** Identifying strategies to provide integrated care for rural patients with diabetic foot ulcers



Promoting Sustainability

- **Collaborative Leadership** – RWHC promotes sustainability, HRSA
- **Member-Driven Decisions** – engagement
- **Effective Communication** – informing others of what we are doing
- **Change-Ready and Adaptable Workforce** – trust; “boots on the ground”
- **Continuous Improvement** – using evidence-based principles like AHA material
- **On-Going Evaluation and Measurement** – data driven
- **Sound Financial Infrastructure** – demonstrating value added is key



Challenges

- Higher than average rates of obesity, poverty and tobacco use.
- Limited standardization on best practices associated with priority conditions.
- Fewer resources available to devote to identifying and mitigating the causes of chronic disease prevalence.
- Decreased participant revenue (due to reduced utilization).
- Provider resistance to standardization and evidence-based practices.
- Loss of focus and commitment to maintain best practices.
- Turnover of staff and leadership positions.



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“When the experts determine that high blood pressure, heart disease and diabetes are actually good for you, you’re going to feel awfully foolish!”



Strategies for Success

- **Develop** and follow the Project Work Plan
- **Obtain** baseline data for measuring
- **Organize** project team and meet regularly
- **Create** Intervention Checklist for Members to work from
- **Share** success stories to help engage others
- **Consistent** scheduled meetings with follow-up in between meetings

It takes time and a lot of effort but it's worth it as we work together to have Rural Wisconsin communities will be the healthiest in America.



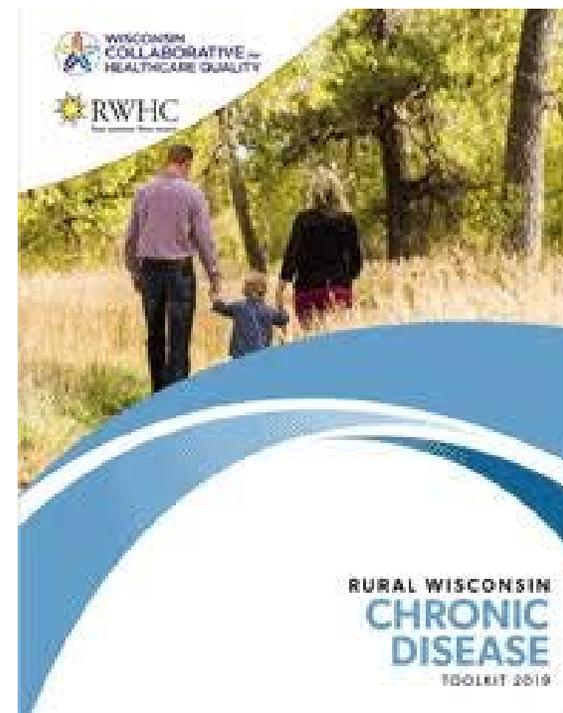
Lessons Learned

- **Facilitate** culture change by providing information with the background of the project—explain the “why”
- **Prioritize** projects and be flexible with the timeline—we are not the healthcare organization’s only priority
- **Adopt** changes based on the organization's specific needs and cultures—understand the community and resources available
- **Include** all staff from the frontline receptionists, clinic and hospital staff, providers, leaders, diabetic educators, nutritionists, coding, IT—eliminate silos!
- **Provide** education to all staff, and continue educating and providing constructive feedback—use PDCA
- **Ensure** buy-in from administration in order to sustain the leadership, funds, human resources and accountability—don’t let it fall off the radar
- **Celebrate** success...recognition with words, food, and showcasing their accomplishments with others



Rural Wisconsin Chronic Disease Toolkit

- Developed in 2018 for RWHC Primary Care Improvement Project; updated in 2019 with improved functionality
- Up-to-date rurally relevant best practices that have shown to be effective in improving chronic disease outcomes
- Resources for effective teams and communication
- BMI
- Diabetes
- Blood Pressure Control
- Chronic Disease Management Resources
- <https://www.hipxchange.org/RuralChronicDisease>



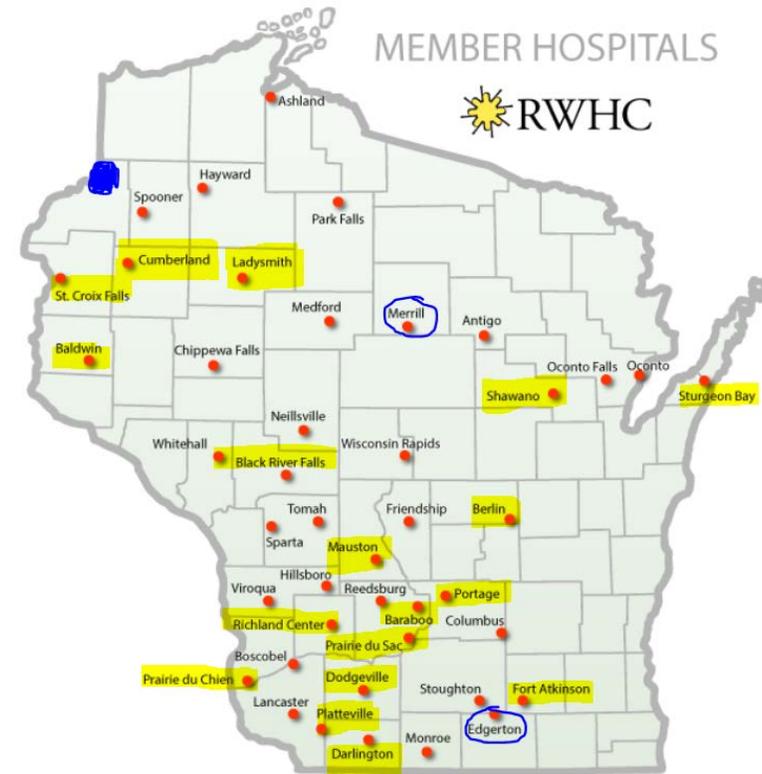


Next Steps...

Current Participants:



Future Project Participants:





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