Chapter 12

Chapter 12

Developing Responses
Researching the Issues

Issue Research and Tools

At this point in the process, the Partnership selected six to eight issue or problem areas from the assessment phase and is now ready to begin the problem solving and decision making phase. A traditional problem solving approach is employed. The steps include defining the problems, searching for alternatives and evaluating them, and forwarding recommendations.

The Partnership forms committees around each of the issue areas. To get started, the members of the Partnership who have agreed to work on the committee should meet to address the following items.

1. **Write problem statement(s)**
2. **Review existing data**
3. **Create list of additional questions for research and education**
4. **Determine who else should be present**
5. **Write up the results of the meeting for full Partnership approval**

- Committees have been assigned an issue area only, and not a specific problem or set of problems to research and solve. The specific problem or problems within that area still need to be

clearly defined. Defining the problem essentially means to describe what the problem is and to project how the group wants the situation to be in the future.

- The committee should review all of the available data from the health assessments. They should become very familiar with the sources and the precise meanings of the results.

- The committee should brainstorm a list of all the questions they would want answered regarding the situation. What is not known? What have other communities done? And so on. The CHIP Coordinator later defines whether the questions require education or research to provide answers. If education is necessary, the proper reading material or guest speaker should be scheduled. If the issue is purely research, the CHIP Coordinator begins the research process. Common resources such as associations or state agencies usually can provide much of what is needed to get started.

- This point in the process is an excellent time to expand the number of participants in the Community Health Improvement Partnership process. Why? Because the issues are clearly identified and those people with specific expertise in a particular issue area can be motivated to participate. You may want to include people who do not reside immediately in your service area as potential participants, if they have the experience you need. Remember, community is defined as a network of like needs or ideas not just by geography.

- Write up the results of this meeting and present it to the full Partnership for their review, recommendations and approval. This is a necessary step. The entire group may have interpreted the issue or problem in a slightly different manner. It is better to check perceptions early and often rather than wait until the end and have all of your work dismissed as meaningless by detached or uninvolved members.

Group Issues in Problem Solving

The committee members need to recognize that the problem solving process is a work in progress. After thinking you have defined the problem precisely and have begun to generating and evaluating, you may learn new things. Indeed, you may find you are trying to solve the wrong problem. The group must not feel compelled to stick with the initial problem definition.

Some other problems during this stage of the process may hinder your issue research. Some groups who have worked on committees in the past tend to rely on experiences that have served them well in the past. The Community Health Improvement Partnership is not an organization which has decision making authority, so the same methods a business uses to assign or tell some department or agency what to do might not work with a coalition type organization.

Committee level discussions should be measured and recorded just the same as the full Partnership meetings. Ideas, thoughts, brainstorming lists, and the results of the activities listed below should be recorded and preserved as part of the record. Something written has permanence.

Some people have pet solutions in need of problems, and they may try to force an inappropriate solution on the group. As the saying goes, if all you know how to use is a hammer, everything looks like a nail. To be creative and truly solve an important community issue, do not pick a solution too early in the process.

"We tried that before and it didn't work" is a statement that is often heard in the problem-solving phase. Do not dismiss past alternatives for this reason. The environment or community attitude about the problem may have changed, making the previously tried approach plausible. The CHIP Coordinator and all Partnership members should agree to allow open sharing of ideas and not criticize ideas as they are forwarded to the group. Ideas should be recorded as mentioned above and see if they resurface. Groups that allow ideas to be struck down too early will stifle member participation.

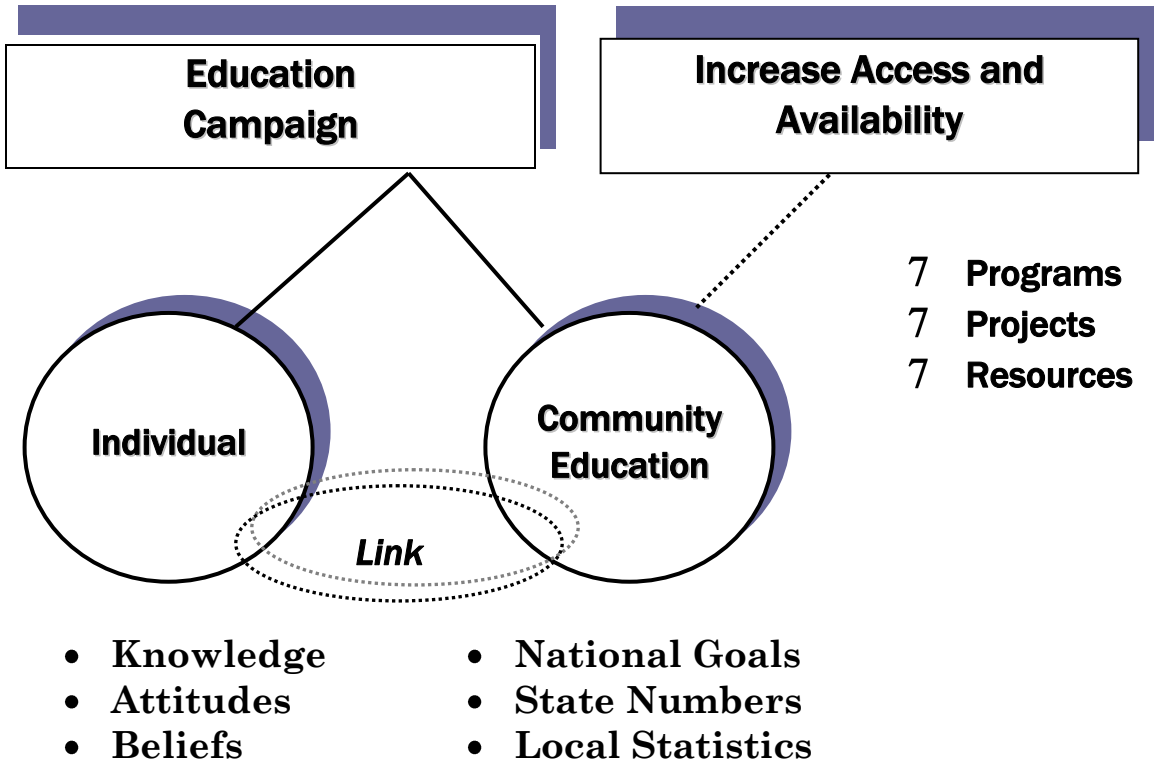
Below are examples of group process techniques that will help the committee and the CHIP Coordinator work through identifying the problem, generating alternatives and evaluating the alternatives.

Problem Pathways

In general, a response to a health problem has two option pathways. You either educate the individual and the community about the health problem OR create or coordinate projects, programs to screen or treat the problem. This is displayed in Figure 12a on the next page. On the left-hand side of the graphic, you see that educational efforts should takes place at two levels – the individual level and community level. Education at the individual level is typically provided by a qualified health professional. The patient's attitudes, knowledge and beliefs about the particular health problem/disease are important for the provider to know. This allows them to develop strategies that have meaning to the patient.

There occurs a link between the individual level education and community level education. Community education can make someone aware of the behavioral or genetic risks associated with the health problem, common means of prevention, early signs to acknowledge the existence of the problem and where to go for help. Community level education is usually tied to local, state, and national comparison numbers. These data sets inform the public about trends, recent treatments, and so on. On the right hand side of the graph is the option to increase the availability and accessibility of programs, projects and services that are designed to meet the particular health issue. A combined approach of both options typically brings better results. Indeed, they should work in consort with each other.

Figure 12a. Problem Pathways



Source: Berhinger, Bruce, Tricks from the Font Line, Virginia Primary Care Association, 1990.

Pre-Set Matrix

If you are very familiar with the issue, it is often helpful to identify the strengths and weaknesses of the issue based on the environments that influence the situation. Simply have committee members brainstorm around the environments.

Figure 12b. Example of Pre-Set Matrix

Environments	Strength	Weakness
Demographic		
Economic		
Financial		
Personnel		
Technological		
Regulatory		

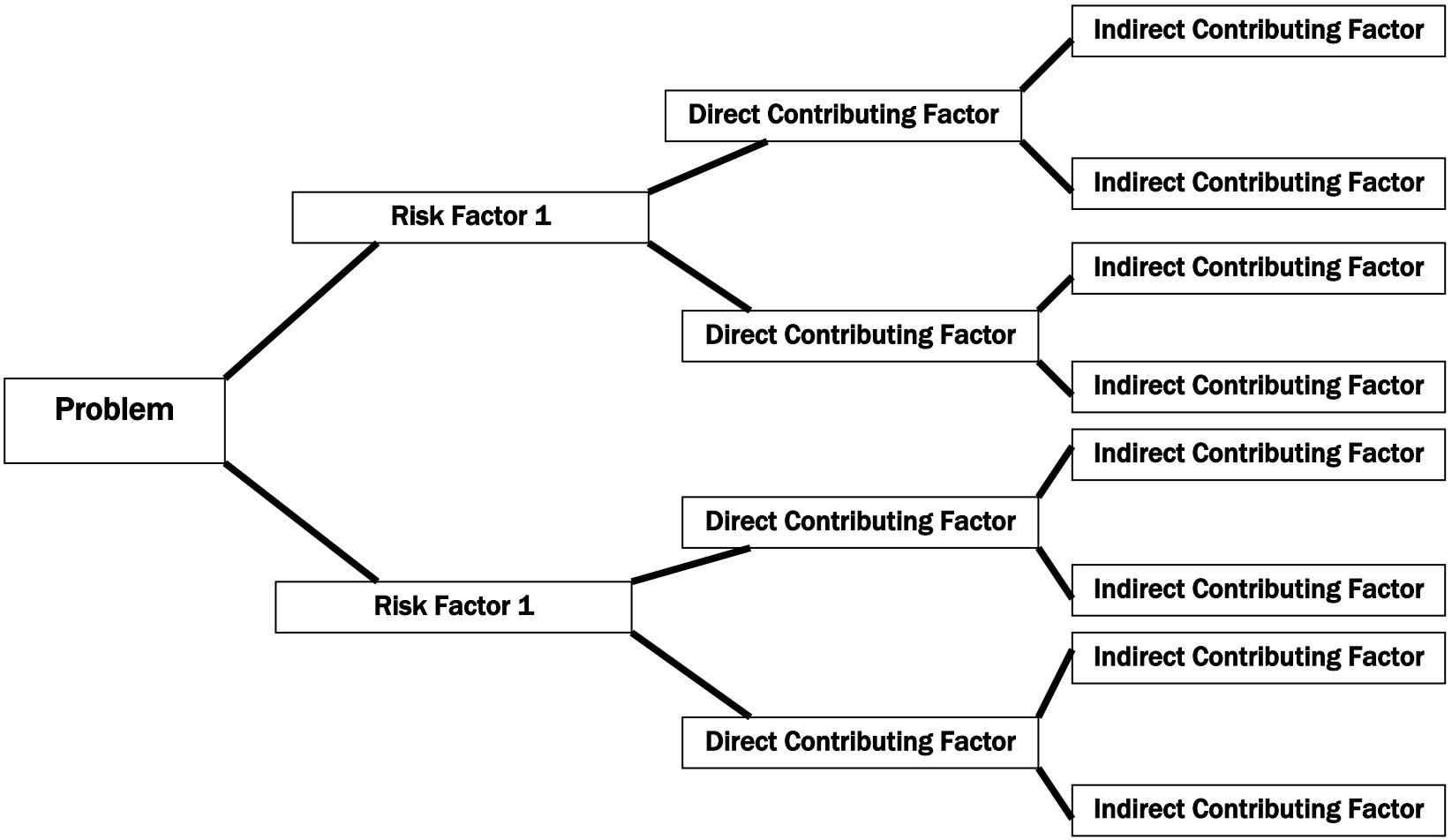
Herring Bone

This method is particularly good at helping you get to the cause of the initial problem. Set the health problem or goal in the left-hand square like demonstrated in Figure 12c on the next page and work backwards. The health care community has typically already identified the Risk Factors. The group then generates their own ideas as the direct contributing factors and the indirect contributing factors. The ultimate strategy should attempt to address the indirect and contributing factors.

Conducting a Herring Bone Process

1. Write problem or the issue along the spine
2. Identify and list all the risk factors to the problem or issue
3. Identify and list factors directly contributing (direct contributing factor) to each risk factor
4. Identify and list factors contributing to each identified direct contributing factor

Figure 12c. Herring Bone Model



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Chapter 13

Chapter 13

Developing Alternatives and Strategies

Generating Alternatives

In Chapter 12 you clearly defined the problem which you feel needs to be addressed and have gathered some information regarding other peoples response to similar issues. Now you need to move to the second activity of problem solving -- generating potential alternatives for addressing the issue. Once the list of potential responses is made each of those alternatives needs to be evaluated before selecting a response.

The Policy Quadrant Method

The Policy Quadrant method provides the Partnership an easy simple, structured process for generating alternatives and strategies. This method requires group creativity and some education of the Committee members before it can work. However, the policy quadrant is a very effective tool if properly used. The concept is that all of what a government or organization does in developing policy action fits into one of the four action quadrants delineated in Figure 13a on the next page.

There are two main thrusts to this tool. One, the activity either costs the organization money (Monetary) to accomplish or it doesn't (Non-monetary). Two, the organization undertakes the activity itself (Direct) or gets another organization to do it for them (Indirect). Each of the quadrants is described below. The following example helps illustrate this method's practical application:

The Problem: Head injuries for children under the age of sixteen triangulated out of the community health assessment process. Further research by the Partnership revealed many of these head injuries were sustained by children not wearing safety helmets while bicycling. Consequently, the Partnership focused its alternative solution generation on increasing the use of bicycle safety helmets among children, and they used the Policy Quandrant approach to generate alternatives.

The upper left-hand quadrant represents a ***Direct/Monetary*** policy action. In this quadrant the organization or government entity can provide the good or service itself or directly purchase that good

Figure 13a. Policy Action Matrix

(Issue stated here)	***Direct***	***Indirect***
Monetary		
Non-Monetary		

from the private sector. This action typically involves a redistribution of wealth in the community. In short, people are taxed and then the good is provided without expense to the consumer. In non-government organizations, it means the service is provided as a cost of doing business. Activities in this quadrant are typically the most expensive and the most difficult to achieve.

In this quadrant, the Partnership listed this potential alternative:

- give away the helmets to residents through the public health department or hospital at no cost. All people would be eligible regardless of income. The organization would cover the cost of the helmets.

The upper right-hand quadrant represents an ***Indirect/Monetary*** policy action. In this quadrant, the organization or government entity taxes or subsidizes the activity. The organization can provide compensation, subsidies, payments, vouchers, grants, loans, tax credits, exemptions, or insurance of some type. The organization also can enact commodity taxes, tariffs, fines, quotas, and establish pricing mechanisms.

In this quadrant, the Partnership developed these potential alternatives:

- create vouchers for low-income people to purchase helmets; and
- have the police department run a loaner program.

The lower left-hand quadrant represents a ***Direct/Non-monetary*** policy action. The regulation of behaviors usually occurs in this quadrant. The government or organization simply prohibits or requires some type of action. This is accomplished through rules, regulations, standards, fines and licensing. For this quadrant, the Partnership developed these possible actions:

- fine parents whose kids are caught not wearing helmets; restrict the places where bicycles can be ridden by those under sixteen
- require all stores which sell bicycles to include a helmet in the price of the purchase
- license all bikes and make helmet use a requirement for licensure
- deny kids the privilege of riding bicycles to school or anywhere else if they fail to wear a helmet
- require kids caught without a helmet to watch a film about long-term rehabilitation from head injuries.

The lower right-hand quadrant represents an ***Indirect/Non-monetary*** policy action. This involves educational and informational efforts to modify behavior. You inform people of the risks and implore them to follow through.

- The possible solutions developed by the Partnership under this quadrant included:
- hold a bicycle safety rodeo;
- distribute bike stickers that say, “the operator of this vehicle

should be wearing a helmet;"
- hold bike safety educational sessions in the schools; and
- run public service announcements.

To conduct the policy quadrant method of option generation with your Partnership, describe the tool and then allow the group to brainstorm potential responses for each of the policy quadrants. You will find it often requires several different policy approaches to truly address the problem.

Generating Alternatives by Modifying Existing Solutions

Sometimes resources and programs already exist to meet a particular problem, but the data from the assessment tells us the problem is still prevalent or, perhaps, even growing. Let's use childhood immunizations as an example to illustrate this technique. Consider the following statements surrounding this issue:

- The federal, state, and local health officials have made all childhood immunizations free.
- The community still has only a 50 percent compliance rate for two-year-olds.
- Research and science tells us immunization work -- the solution is to inoculate.
- The Partnership determines the solution clearly is not the problem, but, instead, the method for delivering the service may be the problem.

Now, put yourself in the place of this fictitious Partnership and determine how you could modify the solution (immunize) using the methods for modifying listed below:

Ways to Modify Existing Solutions

Magnify	Make larger, higher, longer. Add resources. Apply more often. Duplicate. Multiply. Exaggerate. Add new components.
Minimize	Make smaller, shorter, narrower, lower, lighter.

	Omit, remove, split apart. Understate.
Substitute	Switch components. Switch order. Use different materials. Change location. Change the sponsor.
Combine	Blend two approaches. Combine Units Combine purposes. Combine sponsors.
Rearrange	Reverse. Invert. Change sequence. Speed up. Slow down. Randomize. Place in a pattern.
Location	Single location versus multiple sites. Scattered locations, nodes, linear arrangement. Permanent versus temporary. Mobile, rotating, dense, sparse, mixed, segregated. Layered or juxtaposition. Adaptive reuse.

From: Alex Osburn, Applied Imagination: Principles and Procedures of Creative Problem-Solving, 3rd ed., New York 1963

Seeking Alternatives by Life Cycle

Life cycle planning involves predictable morbidity (illness) and mortality (death) as one progresses through each defined stage of life. In each life cycle, we experience needs in the areas of health promotion and disease prevention, have some acute self-limited problems, and experience some chronic disease. The tables provided on the following pages show typical issues in each life cycle. This list is not exhaustive, and special populations have their own specific needs. Your community members can add to the lists based on local conditions. Your committee can check to be certain that some type of education or service is a part of the community's health resources to address the problems.

Life Cycle Needs in *Health Promotion and Disease Prevention*

Prenatal	Pediatric	Adolescent	Adult	Geriatric
• Genetic Counseling • Parenthood Education in Schools • Prenatal Classes • Nutritional Counseling • Risk Avoidance, tobacco, alcohol, drugs, radiation • Amniocentesis • Childbirth and parenting classes	• Breast feeding • Well-Child • Immunizations • Attention to growth and development stimulating and healthy environs • Attention to healthy habits, nutrition, exercise • Dental care and fluoridation • Injury reduction, car seats, falls, stroller use • Poison Center • Infant CPR • Home Safety	• Injury reduction with special attention on roadways. Seat belt use, helmets, pedestrian safety • Firearm Safety • Attention to healthy habits, nutrition, exercise, avoidance of drugs, alcohol, tobacco • Sex education, including sexually transmitted diseases and family planning • Immunization updates • Mental health counseling, suicide issues • Fitness in sports	• Attention to healthy habits, nutrition, exercise, avoidance of tobacco, alcohol, drugs • Occupational health concerns • Environmental health concerns • Cancer screenings • Risk reduction of cardiovascular disease • Dental care • Mental health counseling • Safety in homes	• Maintenance of independence • Home safety • Immunizations - flu and pneumonia • Mental Health issues, feeling needed, social activity • Health maintenance exams • Polypharmacy • Exercise • Nutrition

Life Cycle Needs in *Acute Self-Limited Problems*

Prenatal	Pediatric	Adolescent	Adult	Geriatric
• Anemia • Fatigue • Bleeding • GU infections • Sexually Transmitted diseases • Morning sickness • Post birth depression	• Fever • Respiratory Infections • Rashes and skin problems • GI upsets and diarreheal disease • Growth and development concerns • Poison Ingestion • Injuries • Dental caries • Urinary Tract Infections • Parasitic Infections	• Respiratory Infections • Acne and skin problems • Growth and development concerns • Injuries minor and major trauma • Sexually transmitted Diseases • Pregnancy • Emotional crises • Drug Overdose • Dental caries • Parasitic Infections	• Respiratory Infections • Gastrointestinal problems • Stress • Family Issues • Emotional Crises • Periodontal disease • Parasitic Infections • Trauma	• Respiratory infections • Lower Gastrointestinal Problems • Grief/Loss • Urinary Problems • Hypothermia/ exposure problems

Life Cycle needs in *Chronic and Continuing Problems*

Prenatal	Pediatric	Adolescent	Adult	Geriatric
• Hypertension • Obesity • Diabetes	• Allergies • Anemia • Abuse • Seizures • Learning Disorders • Behavioral problems • Obesity	• Growth and Development Concerns • Allergies • Bulimia • Obesity • Depression • Peer Problems • Acne • Family Stress • Alcoholism • Drug Addiction	• Obesity • High Blood pressure • Allergies • Family Stress • Alcoholism • Drug Addiction • Cancer • Sexual Dysfunction • Depression • Occupational exposures • COPD	• Hearing and Vision Problems • Cardiovascular Disease • Diabetes • Aching Joints • Alcoholism • Elder Abuse • Cancer • Depression/ Loneliness • Alzheimer's

Evaluating Alternatives

Alternatives generated by the Partnership need to be evaluated in order to ensure the response to the problem is appropriate. A simple and effective tool is the PEARL Test. "PEARL" is an acronym.

To apply the PEARL Test to alternatives generated by the Partnership, ask the group to answer the questions that appear after each PEARL consideration and decide whether the alternative meets the conditions of the test.

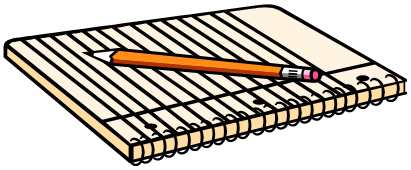
P	**Propriety**	Is the program or alternative for the health problem suitable? Will it address the concern in terms of the magnitude of the problem or the intensity of the problem? Does it seem to be an effective response?
E	**Economics**	Does it make economic sense to address the problem? Are there economic consequences if a program is not carried out? Is the intervention efficient?
A	**Acceptability**	Will the community accept the intervention or program? Is it perceived by the community to be needed? Will the agencies needed for implementation go along with the recommendation?
R	**Resources**	Is funding available? Where will it come from? Are there grants and other initiatives to make the program work? Will multiple organizations contribute?
L	**Legality**	Is it legal? Do current laws, rules, regulations allow program or intervention activities? Does it infringe on basic human rights?

Writing Recommendations

Once the Partnership has generated, evaluated and selected solutions to address the top issues/problems, you present the recommendations to the community for comment and validation Your recommendations for community health status improvement/health resource development is the last function of the Community Health Improvement Partnership. Remember, while the Partnership has been given the responsibility for developing recommendations, it has not been given authority to approve or implement the suggested changes. Those functions of the process belong to the boards of directors or other authorities of your Partnership's sponsoring organization.

This may frustrate Partnership members who have labored intensely over the issues. However, their frustration should be short-lived. Past community development in health care processes have shown that board members and other health care leaders are quite receptive to implementing recommendations made by the community groups like the Partnership – *when they have been kept informed of and involved in the process.*

Before finalizing the recommendations, the Partnership shares its recommendations with the Select Ten groups for their review, comment, and approval. If there is clear consensus from the Select Ten on which recommendations to forward, you are almost finished. If there is not consensus, the Partnership needs to address the concerns expressed by the Select Ten and attempt to resolve the disparity.



The back and forth dialogue between the Partnership and the Select Ten continues until a consensus is reached. Consensus means you have your say, not necessarily your way. Further, it implies everyone can leave the decision agreeing to support it. The final decision may not be to everyone's preference, but everyone has agreed to give the decision a chance to succeed. You cannot end the process with a set of recommendations the community is unwilling to support, for the Community Health Improvement Partnership is a community process and the Partnership represents the community -- not itself.

The Partnership is the voice of the people. Therefore, your recommendations must reflect the attitudes, opinions, beliefs and convictions of the community. If your recommendations do not reflect the community's interests, then they are without substance and foundation. They are invalid, and so will be your whole the Community Health Improvement Partnership effort.

With this in mind, a simple issue format is suggested for use in consolidating information developed as part of the Community Health Improvement Partnership process. This is not as much a strategic plan as it is a set of recommendations for which a significant amount of planning research has been completed.

The people who will review the recommendations need concise documents. The level of detail should be balanced against the readability of the document. Too much background and data will turn many decision-makers away. Further, the more detail presented, the more the decision-makers may focus on the detail without seeing the big picture. You have the detail in your records. If they request further detail, you have it available, but do not give them everything. A one or two page document should provide enough background information around each issue.

The Community Health Improvement Partnerships have found it beneficial to invite the board members from the various health care organizations, government officials, health providers, physicians, and other interested parties together for a summit to present the findings. Many have used this as an opportunity to thank those who volunteered by making a potluck dinner or luncheon as part of the summit.

A one-two page summary for each of the issues to be addressed should include the following information:

- The Community Health Improvement Partnership
- Name of the Committee
- One sentence summarizing the charge given the committee. What was its task? What problem did it seek to resolve?
- A few paragraphs describing how the issue was selected. Present the qualitative and quantitative assessment information from the triangulation process in a narrative form.

- A few paragraphs summarizing: recommended actions, other alternatives explored, and other issues supporting the recommendations. Multiple approaches to problem solving are welcome.
- A few paragraphs summarizing what action steps should be undertaken with anticipated timelines.
- Lastly, there should be the estimated cost or budget impact information and recommendations regarding where the funds can be generated.

After a successful summit, many Partnership teams have been asked to be partners in formal planning and implementation by the sponsoring organizations. While this is predictable, the mission of the Community Health Improvement Partnership teams changes significantly if they become involved in implementation.

Up until this point, the Partnership and the CHIP Coordinator have remained neutral on issues while trying to solve problems. They have not advocated one solution as better than another until the final recommendations are made. The Partnership and CHIP Coordinator facilitate public discussion and encourage citizen involvement. The role changes from facilitators to advocates if they become involved in promoting implementation.

This is not an argument against involvement in implementation. The Partnership and sponsoring organization merely need to recognize the Community Health Improvement Partnership process has ended with the drop of the gavel at the summit meeting.

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Chapter 14

Chapter 14

Applying the Community Health Improvement Partnership to Today's Health Care Delivery Issues

The Community Health Improvement Partnership process provides an excellent foundation for establishing new, integrated health care organizations if the a health care service delivery organization selects to move in that direction. The levels of integration vary greatly depending on which issues or problems the organization is responding. It may be a simple memorandum of agreement between the schools and the hospital to deal with injury prevention, or it could entail bringing the health and human service organizations together under one organization umbrella. This chapter provides information and tools to allow organizations to make informed choices about inter-organizational relationships and inter-community relationships.

What is driving the need for collaboration or integration in the health care industry? Consumers. In response to rising health care costs, employers with costly health care plans, health care providers and insurance entities are seeking ways to reduce costs while maintaining and improving quality. One way is to be better coordinate the delivery of services both vertically and horizontally. A major driver behind improved coordination is managed care. Managed care, in its purest form, can be simply defined as applying the appropriate health resource at the appropriate time. In order to be successful, managed care demands coordination and control of health resources.

Managed care represents a significant shift in the manner in which health care services are organized and delivered. First, it emphasizes primary care as the most efficient and effective component of the health care delivery system as opposed to high technology based specialty care. Within the primary care component exists the emphasis

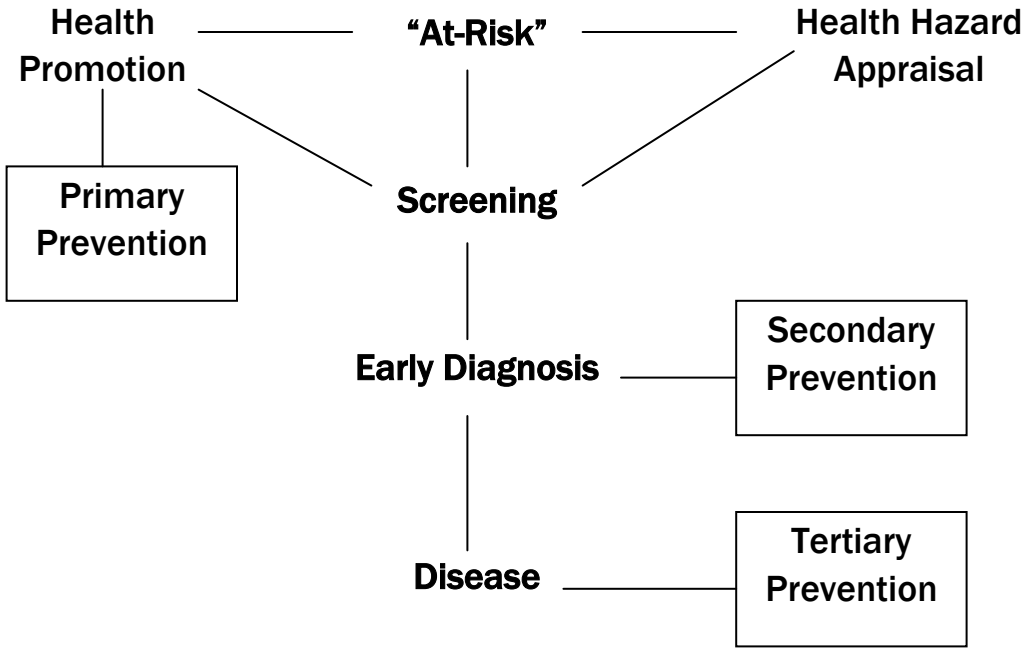
of health promotion, disease prevention and early detection of health problems. Prevention occurs at three levels as described in Figure 14a on the next page. It is based upon the assumption that the level of disease within a population is predictable based upon the various life cycles as noted earlier. The epidemiology, defined as the prevalence or causes of disease within a population, should determine how the health care system responds to a client. All of us, because of age, gender, environment, genetics and behaviors are "at-risk" for certain health problems. Primary level prevention includes the promotion of good health habits to prevent the onset of disease. To effectively manage a person's health, a health hazard or risk appraisal is a necessary activity. If a client presents a history or tendency toward developing poor health, (managed care definition) the appropriate resource deployed at the appropriate time is a health screening activity of some type. If the presence of the disease is not found, the provider re-emphasizes the primary prevention activities in health promotion. If the screening reveals early diagnosis of a health problem, secondary level prevention activities are deployed. Finally, if the disease is in later stages, tertiary prevention activities and appropriate treatment are administered. All of these stages bring the patient back to the most efficient and effective manager of their health, the primary care provider.

Managed care, in its purest form, can be simply defined as applying the appropriate health resource at the appropriate time.

Second, managed care represents a philosophical shift from being unconcerned with the amount of resources spent to diagnosis and treat a patient to being very accountable for costs involved in treating a patient. This is where many consumers become skeptical about managed care. They believe if they are a part of a managed care system, they will not get the services or quality of care they feel they need. This is based partly on past experiences under fee-for-service.

Under fee-for-service, the patient was able to seek expensive and often inappropriate specialty services without prior documented need. In short, they were seeking more than the appropriate care at an inappropriate time. In the past, the health care provider was rewarded for allowing this to occur. How? Because they were reimbursed for the care they provided regardless of whether or not it was needed.

Figure 14a. Levels of Prevention
Epidemiology



How does that change in managed care? In the past, the relationship between the patient, provider and insurer was like the straight line drawn in Figure 14b below. The consumer bought health insurance, sought care from any provider, and the provider billed the insurance company and was then reimbursed. The shift occurs now in that the providers and the insurance company and the patient are linked more in a triangle as shown in Figure 14c on the next page. Note, that there is now a direct, functional connection between the insurance mechanism and the provider. It links both the financing and the delivery of care. Rather than paying an insurance premium under a basic indemnity plan and then consuming the resources as they see fit, the insurance company now has negotiated with the provider what they will pay for based on the appropriateness of the service.

Figure 14b

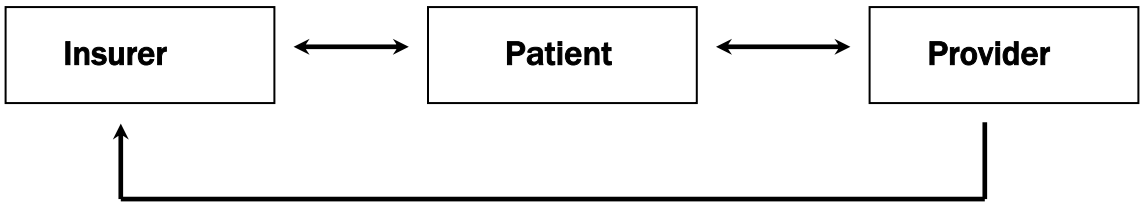
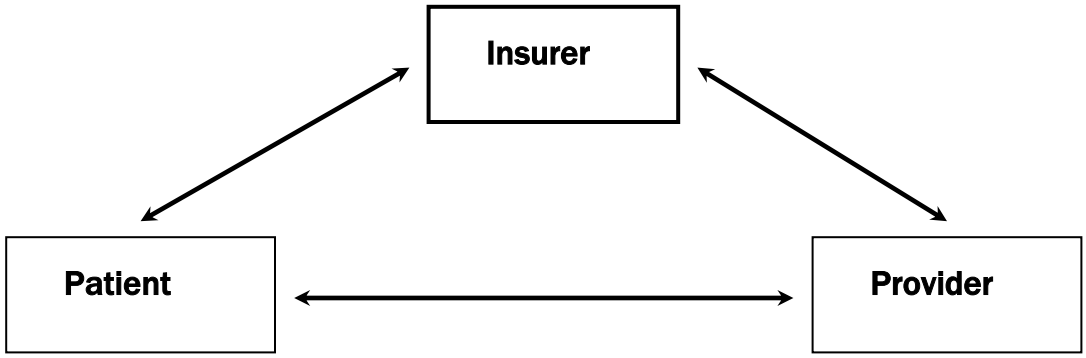


Figure 14-b



The next level of change in the relationship between the provider and the insurance company is called capitation. Under a capitated plan, the providers are given a set amount of money to provide the care a patient needs. This set amount of money is known as a ***Per Member Per Month*** (PMPM) agreement. By limiting the amount of dollars spent before the services are delivered, the insurance company and their consumers (employers, taxpayers for Medicaid and Medicare, and individual purchasers) are able to predict and keep costs from rising. The providers are given the funds up front, and if they keep their patients healthy by providing the appropriate level of service (health promotion, prevention) at the appropriate time (early intervention), they will have money left over, which becomes profit.

This area of profit is based on the assumption that care is cheaper to provide in the early stages of disease than in the latter stages when more technology and invasive intervention is required. If the providers squander resources and spend more, they lose money. They accept financial risk for managing the patient's care. And, as any business knows, that is the basis of the free enterprise system. In a competitive business environment, the company that provides the highest quality goods and maintains costs by being efficient and effective will be the most profitable.

Now the patient asks, "if my provider makes more money by having me use less services, how can I be certain I'm getting the care I need?" This is a legitimate concern and most assuredly the biggest fear in being part of a managed care plan. However, there are two levels of protection. The consumer may have a choice between insurance

companies and plans. In a free enterprise system, the consumer's knowledge and ability to buy something somewhere else is paramount. You can take your business elsewhere in a competitive environment. Federal anti-trust laws protect your choice. If the consumer feels they are not getting good value for their money, they should be able to go elsewhere for the service. However, the burden is on the consumer.

Consumer Protection

Another issue is consumer knowledge. "The medical system is complex and consumers are not informed purchasers, how can they make the right choices?" Your second level of protection is managed care organizations providing information regarding the plan and its providers and a measure of the plan's and providers' quality. If the insurance company cannot or will not provide this information, the buyer, in this case an employer, would be wise to look elsewhere.

What type of information should be available to the purchasers? Customer satisfaction surveys measure perceptions, attitudes and beliefs about the health care received. However, this information is not necessarily factual or outcome related. Outcome based data evaluates criteria established by the National Committee on Quality Assurance (NCQA). This inter-disciplinary team including administrators, physicians and others, agreed to certain items that would measure a managed care plans emphasis on keeping people healthy and other quality functions. The items they selected for the managed care "report card" are clearly measurable and are good estimates of appropriate levels of resource deployment. One type report card produced by the NCQA is called the ***Health Employer Data Information Set 4.0*** (HEDIS). Most report cards for managed care performance are based upon this original work.

Managing Care

How do managed care plans actually "manage" care? What strategies do they employ? First, managed care plans use a variety of techniques to ensure the appropriate resource applied at the appropriate time. These techniques include pre-admission screening, utilization review, discharge planning, second opinion for surgery, same day surgery, home care, case management, referral authorizations, cost sharing through co-payments, quality and practice information systems, and a defined set of providers who agree to share financial risk. These techniques attempt to reduce the need for services by emphasizing prevention and appropriate use of the health care system. Second, they reduce variations in medical practices by providing comparative information. Third, they reduce the cost and become efficient by eliminating duplication of services and fragmentation of the system.

Most of these changes in the delivery and financing of health care have been initiated in urban areas. Large numbers of urban people are now covered under managed care plans. Further, to control taxpayer expenditures, Medicaid and Medicare plans have also entered into capitated payment mechanisms.

Managed Care in Rural America

Managed care does not eliminate the need for tertiary health services. Specialty care at end stages of disease is not abandoned, it is simply better managed and controlled. There is still need for oncology (cancer services), cardiology (heart services) and other sub-specialty services. Those services have always mainly resided in urban rather than rural areas. Rural residents who need these services are referred to and travel to places where these services are provided. Because specialty services are now more closely managed, there needs to be a wider base of primary care providers from which appropriate referrals can come. Therefore, the urban-based managed care plans have begun to reach out to rural populations with their products with the intent of maintaining efficient and effective use of their specialty providers.

Rural providers at all levels do not always welcome urban managed care outreach with open arms. They may fear the urban organizations will skim the privately insured and more healthy population from the rural community and leave them with the less profitable Medicare and Medicaid and uninsured patients. Because rural areas have smaller populations, they create a lower volume of services. In a capitated managed care system, rural providers have less people to spread the financial risk over and are thus very vulnerable to a few highly costly clients driving them into bankruptcy.

Some rural providers feel overwhelmed by the logistical requirements of participation in managed care plans. They may lack the proper management information system or business expertise. In addition, rural providers, especially non-profit community based or publicly held providers, fear they will lose control to non-local organizations whose interests may not be in keeping with the local values of the rural community.

However, resistance is not the only option rural providers have for dealing with managed care. They actually have a number of options:

1. They can react to what is brought to them and decide if they want to participate. If they choose not to participate and another competitive provider in their community chooses to participate, they may lose patients whose insurance plan requires them to see only participating preferred providers.

2. They can choose to participate and negotiate a payment that is agreeable to both parties.

3. They can attempt to sell their business to the managed care company and become an employee of that business rather than a business owner.

4. They can form a network with other providers in the community and region and create an integrated mix of service delivery. This can provide the rural provider more leverage and bargaining strength when negotiating with the insurance company.

5. Rural providers can network and form their own managed care plan (commonly called ***community health plans***) where they control the delivery and finance functions and assume the financial risk of care.

Networks

As described in Numbers 4 and 5 above, networks can be an effective tool for dealing effectively with managed care. They can also be effective for reducing costs, improving and standardizing quality of care among diverse providers spread across a region, and improving access to specialized services, especially for rural residents.

The differences between network forms can be found in the level of integration. Integration means the amount of autonomy each of the individual organizations retain in their relationship to the oversight organization and the presence of financial risk. These organizations have many names, which contribute to the alphabet soup of health acronyms. They include Preferred Provider Organizations (PPO), Physician Hospital Organizations (PHO), Independent Practice Associations (IPA), Integrated Delivery Systems (IDS), Management Service Organization (MSO), the American Hospital Association's Community Care Network (CCN), Health Maintenance Organizations (HMO), Provider Sponsored Organizations (PSO), and Provider Sponsored Networks (PSN). There are others and their names seem to change monthly. Should you be interested in pursuing these types of options you will need to seek legal expertise.

In rural areas where there is often little consumer choice (except to drive out-of-town), organizations that come under one umbrella organization have to avoid anti-trust issues. The anti-trust issues generally fall under a few well-defined issues. Network organizations cannot exclude other providers from participation. They cannot divide up the market. They cannot fix prices, and they cannot otherwise involve themselves in monopolistic practices.

While not a substitute for legal advice, the Community Health Improvement Partnership process can be a valuable tool in evaluating your network and managed care options.

- The process educates and informs the community about the issues and current trends in the environment.

- It gathers information the community and health care system can use to respond to the health status issues of the community promote wellness and prevent disease.

- The Community Health Improvement Partnership process provides a vehicle for bringing disparate groups together so they can begin the process of building networks.

- It ties the general community, business sector and health providers together around the common purpose of improving community health.

- It can result in service integration and cost efficiencies by allowing the community to define the appropriate or right-sized scope of service in the service area.

- Lastly, for rural areas, it can give loosely knit health care providers an opportunity to come together to present a united front against outside organizations which seek to divide and conquer the rural market.

As the Community Health Improvement Partnership seeks to improve the health status of the population and improve on the health resources available to meet community health needs, it often becomes necessary for organizations in the community to work together somehow. What they do and how well they do together is usually based upon the threat or need, the level of trust between the organizations and how much they are willing to share. Spending time together, creating a common vision, and holding each other accountable to the good of the community can satisfy all this.

Critical Access Hospitals

The federal government is also encouraging rural health network development. Legislation in the Balanced Budget Act of 1997 created a new type of health care facility called a ***Critical Access Hospital*** (CAH) which is part of the Medicare Rural Hospital Flexibility Program. The CAH was developed around the experiences of earlier efforts of limited service rural hospitals through the Essential Access Community Hospital / Rural Primary Care Hospital (EACH/PRCH) and the Medical Assistance Facility (MAF) models.

The concept is quite simple. In order to preserve access to basic primary care, urgent and emergency medical services in smaller rural communities, some type of facility other than the expensive full-service acute care hospital is required. The advantages the smaller community gets if it decides to pursue CAH designation is reduced licensure requirements (i.e. mandated staffing and expenses) and, most likely, more favorable reimbursement formulas. In return for these advantages, the hospital must agree to limit its scope of service to keep inpatients no more than 96 hours and have no more than 15 inpatient beds. There are other requirements, but these two are the most important.

Two activities should take place as part of CAH consideration. They are: 1) community planning and decision making and 2) financial feasibility planning.

A CAH is one organization form or structure now available to meet rural community health needs. The structure your organization takes should follow a desired list of functions. Form follows function. These functions -- services the facility provides -- should be collectively decided by the community itself. Converting a full-service acute hospital to a Critical Access Hospital requires careful consideration. The Community Health Improvement Partnership fulfills many of the recommended activities that should take place before making the change. Federal guidance suggests that community members be part of the decision making process to convert to a CAH. The CHIP structure allows for this and much more. The CHIP can help determine scope of services that will meet the health care needs of the community. The Partnership can evaluate information gathered from various health assessments and compare those needs to assets.

Financial feasibility is best left to accounting and health care financial management personnel. They will be able to help determine the cost structure of the hospital and complete necessary pro forma to determine whether reimbursement under the old method of payment will be better or worse than the new method. However, the decision on how to use the results of their analysis should be balanced with the needs, desires, and wants of the community. The Community Health Improvement Partnership serves this role.

You may also want to us incorporate the Inter-Organization and Strategic Options Matrix beginning on Page 258 into your CAH decision making. The tool provides an excellent framework from which to base your decisions.

Should your community be considering this option, contact your State Office of Rural Health for details.

Inter-organization Options

Inter-organizational relationships, such as networks, all fall somewhere on a continuum extending from little integration to full integrated. The further an organization moves toward full integration, the greater the number and more complex the issues that need to be addressed by the organization, for each step further impact a greater number of people and organization assets – tangible and intangible. The relationships are delineated below.

1. **Network/Alliance** - a chain, group, or system interconnected or interrelated with at least one common objective. A network is composed of regional clusters of integrated health care systems that voluntarily join together, under a central organization, to 1) market their services, 2) develop and market purchasing, management and other shared services and 3) raise capital.

2. **Contract Management** - General day-to-day management of an organization by another organization under a formal contract. The managing organization reports directly to the board of trustees or

owners of the managed organization. The managed organization retains legal responsibility and ownership of the assets and liabilities of the facility.

3. **Joint Ventures** - A grouping of two or more persons and/or entities for a specific business undertaking in which they invest and share risk as well as profits or other rewards. The venture can be a partnership or a corporation.

4. **Limited Affiliation**- A grouping or association of two or more organizations which is not a permanent union. Because the organizations typically maintain some degree of "separateness," they retain the ability to dissolve the grouping upon concurrence of a specified event or at the end of a pre-determined time,

5. **Leases**- Exclusive possession of an organization's real and personal property, management and operation of the business for the lessee's own account for a specified period of time under a formal contract. The leasing and managing organization is the licensed provider, assumes legal responsibility for the operation of the facility, and retains the facility's net revenues. It pays the owner of the assets a fixed or variable sum for the right to occupy and operate the facility.

6. **Merger**- The union under state law of two organizations (A and B) in which Organization A ceases to exist and organization B continues to exist. In a merger, Organization B continues to exist retains the identity and acquires the assets, liabilities, franchises and powers of Organization A, which ceases to exist.

7. **Consolidation**- The union under state law of two organizations (A and B) in which both organizations unite to form a new organization "C" and the original organizations (A+B) cease to exist. The new Organization C acquires the assets and assumes the liabilities of the original organizations (A+B).

8. **Acquisition**- The union by purchase contracts of two organizations (A and B) in which one organization purchases the business of the other. Either Organization A sells its operating assets to Organization B, and Organization A continues as a foundation or dissolves, or the stockholders of Organization A sell their shares of Organization A to Organization B.

9. **Full Affiliation/Sponsorship Change** - A grouping of two or more organizations typically under a holding or management company. The organizations may retain their separate identities, however, they do not individually retain their ability to dissolve the grouping.

When an organization decides to pursue any inter-organization option such as one or more those previously listed, many complex issues demand consideration. Failure to fully consider these could violate the board's duties of due care and loyalty, and violate the law. Again there is no substitute for having your own competent legal advice. Legal issues that need to be considered include:

- State and federal corporation statutes and laws
- Corporate articles of incorporation and by-laws
- Fiduciary aspects
- Licensure
- Existing contractual commitments
- Medicaid and Medicare Rules and regulations
- Existing Grants and Obligations
- Insurance
- Anti-Trust Issues
- ERISA and relatives
- Labor Relationships
- Medical Staff-Bylaws
- Endowments
- Securities Law
- Bulk sales law
- Corporate practice of medicine
- Patient Records

Evaluating Your Options

Weighing the issues involved in an inter-organization strategy or option can overwhelm even the most experienced director or manager.

Not surprisingly, then, many who have entered into inter-organization arrangements did so without fully understanding this issues until well after the contract was signed. The tool, beginning on Page 256, provides decision-makers considering inter-organization strategies a structured process for thoroughly examining the ramifications of such options. Not only does it help you prioritize your options, it provides you with a menu of issues that require your consideration before pursuing an option – evaluative questions you might not think to ask until it is too late.

Many of these issues touch on values and this is important to understand. Evaluating your options include more than the dollar value. There are also management values, political values, and social values to consider.

Rosenbloom defines these differences well in his text Public Administration: The Managerial, Political and Legal Perspectives. Management values represent the core assumptions of for-profit businesses. These can also be applied to government services. When people say, "government should be run like a business," they are speaking of applying management values to public organizations. The values of management are efficiency, effectiveness and economy. Management is associated with the execution of day-to-day activities of an organization. The political values are representation, responsiveness and accountability to someone. Political values are typically embodied in the governing board or with elected officials. Political activities are associated with the making of policy. For example, a board (political) makes a policy and tells the administrator (management) to create efficient and effective procedures to implement the policy.

Management structure is based on the core values of economy, efficiency and effectiveness. Thus each position within the structure should be based on merit with a bureaucratic structure composed of a chain of command and line staff. Board structure embraces organizational pluralism. This is to ensure various interests are represented and the organization is responsive (one of their core values) to those interests. Pluralism has little to do with efficiency and effectiveness of decision making. In fact, the more diverse the interests represented, the harder it is to find agreement.

Management solves problems and makes decisions based on the rational scientific method. Management states the problem, generate alternatives, evaluate the alternatives and select the one best way of doing something. Political problem solving and decision making involves agreement, public opinion, debate and perhaps consensus. The result of a board decision may not be the one best way, but it may be the one most of the members can live with.

Management makes budget decisions based on cost/benefit analysis, while boards typically distribute the benefits and/or burdens equally. For example, let's say a group of individual organizational providers come together, yet each each maintains accountability to its organization. If they have a sum of money to share among themselves, they would likely take that sum and divide it equally among the group rather than evaluate where the best bang for the buck would occur. They believe this approach will keep everyone happy. The opposite decision of facing a budget shortfall also provides an example. How many times have you seen a governing board simply tell all departments to cut their budgets by 15 percent? The mandate has nothing to do with cost/benefit analysis of each department. It simply distributes the burdens equally.

The values and approaches of management and governing boards are not necessarily competing, and one is not necessarily better than the other. In the idea forum, boards and management provide a check and balance to decision making, which is highly valued in any democratic process.

Strategic Options Matrix

As mentioned this tool was created to help decision makers evaluate and prioritize inter-organization options facing them. This tool has also been used effectively to evaluate: new service development, reducing services, building expansion, outreach facility development, and managed care contracts among others.

Assessing Impact of Inter-Organization and Strategic Options ISSUES REQUIRING CONSIDERATION

The following are the critical issues and questions that need to be considered by any organization, but especially public, before pursuing a strategy that may alter the operation or core purpose of the organization.

A) **Survival** – Will this option help the organization survive? Can the organization survive as it currently exists – pursuing the option of status quo?

B) **Community Needs --** Will the option meet the community's health care needs? What does the community tell you it wants in terms of health care services? What do local health status measurements indicate about your community's health care needs? Will the option provide a mechanism for meeting the community's health care needs and wants?

C) **Mission --** Will the option enhance the current mission of the organization? Will your mission need to be changed if you pursue the option? Who will decide what the mission will be in the future?

D) **Market Share --** Will the option protect or improve your market share? What segments of your market does the option appeal to? Are these the segments you want to appeal to and attract?

E) **Profit/Loss --** Will the option create a financial loss (-) or help generate a profit(+)? Will the option potentially make your other services or strategies more profitable, even if the option itself breaks even or loses money (i.e. loss leader)?

F) **New Technologies --** Will the option develop new services and/or make available new technologies for the organization or service area? Does the organization need these services/technologies in order to better pursue its mission and serve its community? Does the option bring new expertise to your organization or give you access to such expertise?

G) **Capital --** Will the option develop new sources of capital for the organization? Does the other organization have resources that it is willing to commit? Does it have a better bond rating?

H) **Revenue Sources -** Will the option expand or diversify our revenue sources? Will it tie you in with insured people who may be under a preferred provider arrangement not currently offered? Will the option produce a profit (how)? Will the option change your Medicare reimbursement status? Will it help you access non operating revenues

I) **Economies of Scale --** Will the option foster economies of scale? Are joint services or purchasing/contracting part of the option?

J) **Further Action --** Will the option foster a closer relationship for possible further collaborative actions with partner organizations? Is this option moving you closer to the goals in the long-range plan?

K) **Reputation --** Will the option enhance the "reputation" of the organization? What is the image of the other organization(s)? Do you want to be associated with their image/reputation?

L) **Skills and Ideas --** Will the option bring new management skills, techniques, services, or ideas to the current organization? Does your organization possess the expertise to implement the option? Will the option require your organization to take on additional expenses to acquire new skills, expertise and resources?

M) **Political Acceptability --** Will the option be accepted by the public? Who is your public and how is it affected by the option? How might the public react if the option is pursued or not pursued? Will the community resist what is being considered?

N) **Stability --** Will the option have such dramatic change on the organization that it could falter because of the change? Can the option be easily integrated into your organization's administrative or clinical environment and your staff's current workload?

O) **Compatibility** – Are your mission, philosophy, future plans or culture compatible with the other organization(s) involved in the option? Can/do the leaders of each organization involved in the option work effectively together?

P) **Existing Personnel --** How will the option affect existing personnel? Will they stay? What will be the process for releasing them? What happens to existing benefit plans? How will current employees be handled? Does the option involve laying off current staff? Will the option require you to hire additional staff or provide additional training to existing personnel?

Q) **Feasibility** – Is the option realistic? Are the other parties (organizations) interested? Are they truly capable of making a deal and keeping their end once the deal has been made? Is your organization capable of meeting its end of the deal? Can you legally pursue the option?

R) **Control --** Will the option cause loss of local control?

S) **Costs --** Is an expenditure of funds or incurring debt part of the option being considered? What are these expenses? Is it an expense or debt your organization is willing and able to accept?

T) **Goals --** Will the option being considered help you achieve your current goals? Change them? Will your mission change?

U) **Style --** Will the option substantially change the "style", "culture", or "value base" of the organization?

V) **Positioning** – Will the option position your organization to better deal with changes in the health care delivery environment? What are some of these changes? If you do not pursue the option, will this have an adverse effect on your relations with the other organization(s) involved in the option? Will it impede your ability to pursue other options with the other organization(s) in the future, place you at a competitive disadvantage with respect to the other organizations or existing competitors?

W) **Intuition --** Do you *feel* this option is a good or bad option, right for your organization as it stands today?

Instructions for using the Strategic Options Matrix

To use the matrix properly, the organization should gather information around all of the issues for consideration listed along the left-hand side of the tool. The list should guide the direction of your assessments and information gathering. The information, once gathered and reviewed, should answer the questions presented with each issue under consideration.

Once the research has been conducted, place the option for integration in the slots at the top of the page. Then ask the participants to respond to each issue individually with one of the following statements. From the perspective of the organization does this issue:

- Positively effect or impact the organization: ***Place a plus sign (+) in the proper cell.***
- Negatively effect or impact the organization: ***Place a negative sign (-) in the proper cell.***
- Has no effect or impact on the organization: ***Place a zero (0) in the proper cell.***
- Require additional information or research: ***Place a question mark (?) in the proper cell.***

When completed, the matrix will contain a number of pluses, minuses and zeros, which are totaled at the bottom of each option column. The total score will provide you with a broad, objective assessment of the desirability of each multi-organization or strategic option being considered. Note that the first option should always be the status quo option. Status quo is simply continuing on your present course. Is the status quo the best option when measured against the key issues for consideration and compared with other options?

Strategic Options Matrix
Evaluating Multi-Organization and Strategic Options

• *(+) = positive impact on issue* • *(-)= negative impact on issue* • *(0)= no impact on issue* • *(?)= need more information*	***Inter-Organization or Strategic Options***				
	Option A: **Status Quo**	Option B	Option C	Option D	Option E
Issues for Consideration					
A) Survival					
B) Community Needs					
C) Mission					
D) Market Share					
E) Profit/Loss					
F) Technology					
G) Capital					
H) Revenue					
I) Economies					
J) Action					
K) Reputation					
L) Skills/Ideas					
M) Acceptability					
N) Stability					
O) Compatibility					
P) Personnel					
Q) Feasibility					
R) Control					
S) Costs (cost/benefit)					
T) Goals					
U) Style					
V) Positioning					
W) Intuition					
Total					

Sources and References

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Rosenbloom, David, Public Administration Understanding Management, Politics, and Law in the Public Sector 3rd Edition, McGraw-Hill, New York, 1993

Chapter 15

Chapter 15

Community Health Improvement Partnership
Just Do it!

The late George Allen, a professional football coach and President's advisor on physical fitness wrote that "a workout is 90 percent inspiration and 10 percent perspiration…doing it is easy, once you get started."

The same principle applies to implementing the Community Health Improvement Partnership process. While the activities may seem overwhelming, they are quite doable and easily understood once a little effort is applied to thinking and acting.

No two rural communities are exactly the same. They face different challenges, have different levels of resources, and have different methods of resolving issues. No manual or guidebook can provide guidance covering all the potential scenarios. There are however, many commonalties between rural communities and rural health systems. These similarities exist because common laws, roles, payer sources, and licensed professionals practice in each community. This manual works off the common ground upon which rural communities reside. If something presented in the manual doesn't quite fit your community, adjust the process to make it fit. Do not simply give up.

During the course of implementing the Community Health Improvement Partnership you will reach certain milestones that should be recognized and celebrated. Recognition and celebration motivate volunteers and help instill community spirit in the process. The milestones include:

- **Gaining approval from a sponsoring organization**
- **Hiring the CHIP coordinator**
- **The creation of the Partnership team and conducting the first meeting of the Community Health Improvement Partnership**
- **The Community-Wide Participation Meeting**
- **Completing the asset and needs assessments**
- **Selection of key issue areas**
- **Developing and forwarding recommendations.**

Between each of these milestones are "feet, yards and laps" that must be traveled before reaching the [illegible]. Short cuts do not exist between each milestone, so avoid looking for or making them.

Improving the health status and health resource capacity of a community is a very satisfying endeavor. Seeing people get health services previously unavailable to them and improving community health are gratifying achievements. Your work in implementing the Community Health Improvement Partnership *will* produce rewards. But do not expect rewards overnight. Processes such as CHIP take time and patience.

When the process seems to slow or when the skeptics raise their voices, keep your focus, keep driving to the next milestone. Remember, the desirability of your end destination, healthy people and healthy communities. What is more, greater satisfaction will come in the long term -- from the knowledge, experience and resources gained in community development. Once this capacity takes hold in your community, many more milestones on different roads in your community will be reached.

This community development approach to health improvement has been implemented successfully in hundreds of communities across America. You can do it and do it well. It will take some perspiration, but mostly it takes a "can do" attitude as inspiration.

Enjoy your trip to your community!