

Forming a Rural Health Partnership Network

Karl Hamner, Paul Kennedy, and Tim Wolfe

Abstract

Walker County, Alabama, population 70,713, typifies health challenges in rural America. The county is poor with per capita income \$10,000 below the national average. It lacks an adequate health care infrastructure — 4 physicians per 10,000 population compared to 7 nationally. The county has severe chronic health problems. For example, there are 67 heart failure deaths per 10,000 population compared to 20 nationally (Alabama Community Health Resource Guide, 2008). There are many other similar statistics, but a new conjunction of health care providers and leaders offers promise for a united approach in Walker County.

Walker County's health care issues are not new. They mirror those in other rural regions of the nation. Providers and community leaders have been struggling with them for decades. To improve access to and quality of chronic disease care in the county, the Walker Area Transformational Coalition for Health (WATCH 2010) was formed.

Forming rural health networks also is not new. In fact, because of its proven effectiveness (Wellever, 2001), the federal government's *Report to the Secretary* (2008), recommends the practice. What is new is the breadth of WATCH 2010, made up of the county's only hospital; a rural health clinic; a free clinic in the county seat; the regional mental health service provider; a family

support service agency; the local office of the Department of Human Resources; two academic institutions (a community college and The University of Alabama); the Chamber of Commerce of Walker County; and two nonprofit foundations (a regional community foundation and the foundation for the hospital's parent organization).

Partners were recruited to maximize the benefits of collaboration between local, regional, and state agencies, both public and private. This diversity will improve the plight of residents with chronic conditions, offering a more comprehensive approach than ever before.

The Challenges

In establishing the network, we faced a number of significant challenges. They included trust, self-interest, turf issues, inertia, and leadership. Trust was a significant roadblock to getting the network off the ground. Potential partners asked, "What's their REAL motivation behind wanting to collaborate?" They also wondered why the federal government would give money to develop and operate rural health networks. Everyone wanted to know, "What's the catch?" A lot of effort went into assuring members there were no hidden agendas for either the lead agencies or in the federal funding.

Another challenge was self-interest. Everyone had to address the question, "What's in it for my agency?" This is especially critical when asking partners to contribute time, resources, or money.

Leaders are still in the process of ensuring that each agency's ability to meet its own mission is enhanced by the scope and planned activities of the network. They are being as even-handed as possible in requesting in-kind contributions to the development and operation of the network.

Two issues related to self-interest are turf issues and inertia. Perhaps the biggest barrier to forming the network is the "silo" mentality that characterizes health and social services in our nation. Federal programs are administered through separate channels. Funding streams are separate and performance and reporting requirements are widely divergent. Together these create artificial service "silos" that are often restrictive and inflexible (2008).

The result is disincentive to collaborate and coordinate services. Stemming from this is an inertia that challenges the functioning of the network. While all network entities are in some way involved in health and wellness, none has all of the components of outreach, services, or access to the public. Operating individually fosters a "not my job" mentality in which staff feel they cannot do anything about issues not within their immediate mission.

Entering into an official networking arrangement changes the service horizon, however. As a network partner, and agency and its staff are motivated and equipped to do something about these related concerns. Individual agencies are no longer a service "dead-end" for the client. Rather, each partner has become a distribution point for further services, ensuring that the client is referred to those partners and/or resources that can help with related problems.

As needs without immediate solutions develop, we are able to craft new or refined solutions. Traditional approaches to medicine do not lend themselves to partnering; rather, they tend to specialization. This network helps all components approach problems holistically, engaging the community and service recipients in ways providers cannot do independently.

Leadership is the final challenge we face, but it also has proven to be part of the answer. Networks do not form themselves. Someone has to step up and take on the initial work in convening the network. We are fortunate that three dedicated individuals decided to work together on that task. By distributing the preliminary work and

responsibilities for the initial stages we ensured success by not overburdening one person.

To be the first director of the network, we identified a former mayor of Jasper (the county seat), a leader all parties trust to direct the network's evolution.

WATCH 2010 will continue building trust and addressing issues like divergent record keeping, reporting systems, confidentiality, data security, and concerns over geographic isolation and transportation. Poverty and lack of health care are intertwined nationwide (see, for example, *Poverty in America*, 2007). Persons without resources cannot afford health care. This is why WATCH 2010 is exciting. It provides a unique solution to the health challenges facing rural Alabama and rural America, linking primary health care providers, social services, businesses, and educational institutions into a cohesive network that will drive efforts to reduce the burden of chronic illness, promoting wellness among underserved rural residents by eliminating some of the major obstacles.

References

- Alabama Department of Public Health Office of Primary Care and Rural Health. (2008). *The Alabama community health resource guide*, 2008. Montgomery, AL.
- National Advisory Committee on Rural Health and Human Services. (2008). *The Report to the Secretary: Rural Health and Human Services Issue*. Rockville, MD.
- Poverty in America*. (2007). United States Government Accountability Office. Washington, DC.
- Wellever, Anthony. (2001). *Shared services: The Foundation of Collaboration*. Academy for Health Services Research and Health Policy. Washington, DC.

About the Authors

Karl Hamner is director of scholarly affairs at the Capstone College of Nursing at The University of Alabama. Paul Kennedy is executive director of the Walker Area Community Foundation. Tim Wolfe is director of grant development and special projects at Baptist Health System in Birmingham.