

Review & Commentary on Health Policy Issues from a Rural Perspective - June 1<sup>st</sup>, 2001

**We Must Stand For Rural Reality, Not Myths**

The following is the complete "Forward" by Dr. Wayne Myers, *Medicare Reform, A Rural Perspective, A Report to the Secretary U.S. Dept. of Health and Human Services*, 5/01:

"You can't really discuss Medicare reform and its implications for rural beneficiaries without first getting a basic understanding of what rural means and what it may not mean. Depictions of rural America often fall victim to a nostalgic vision of peaceful farm country that look and feel like a homogenous subset of the rest of the more urbanized country. The assumptions inherent in that notion tend to create unanticipated problems across the board but particularly so in health care."

"When the Committee asked me to provide a rural 'context' for the report, I thought the best approach would be to examine the myths and realities that often get lost in any discussion about health care, rural America and the Medicare program."

**Myth No. 1: Rural populations are disappearing**

"Changes in the non-metropolitan population are complex because the criteria for designating areas as 'non-metropolitan' have changed over the years. Counties designated as non-metropolitan in 1960 had 66 million people, 37 percent of the nations' population.

By 1996 those counties were home to 101 million people, but many of these counties had become parts of metropolitan areas."

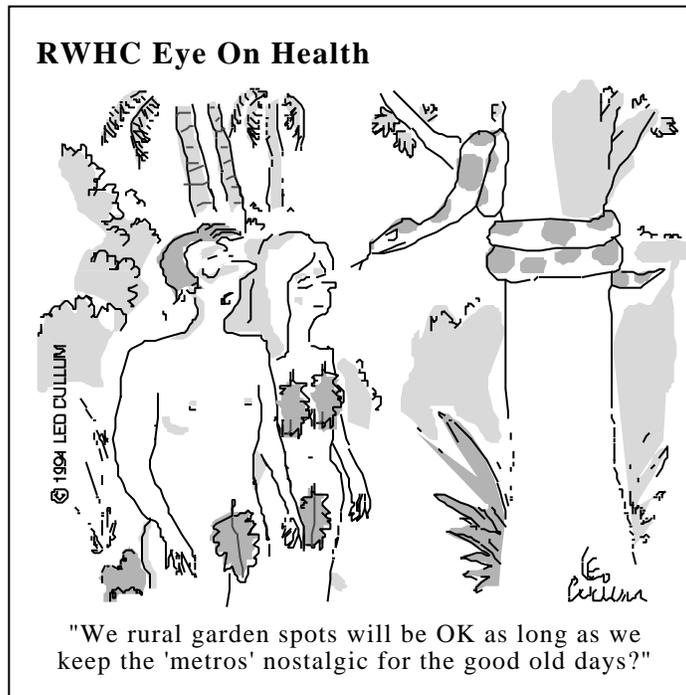
"In 1980 the population of counties designated as non-metropolitan had declined to 48 million, or 27 percent of the United States population. By 1996 the non-

metropolitan population had climbed to 53 million, but constituted only 20 percent of the population. In fact, rural areas are showing modest growth, though slower than that of metro areas. Areas undergoing marked growth are likely to be redefined as 'metropolitan.' Improvements in transportation make it easier to commute to more distant jobs, and qualify more counties for designation as metropolitan, even without changes in population distribution. Although the proportion of the United States population living in non-metropolitan counties is declining the absolute number of non-

metropolitan people is rather constant at around 50 million. The Committee believes this significant population subgroup of Americans merits serious attention to their problems accessing and paying for health care."

**Myth No. 2: Rural health care should be cheap**

"Generally speaking, Medicare payment formulas are widely regarded as approximating the cost of providing health care efficiently. These formulae reflect an accumulation of Congressional choices related to



"Running a business from numbers is like playing basketball while watching the scoreboard instead of the ball. Look after the basics if you want success, and the first basic is the team." Andrew Charles Longclaw in *Gung Ho!*

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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which factors are to be included in estimating the costs of providing 'efficient' health care. The reality is that of the various elements contributing to the cost of a unit of health care, some are more costly in large cities than in small towns, and some are less costly. Physicians and other health care professionals, especially advanced practice nurses and therapists, cost just as much in rural areas as in urban areas. Others, such as custodial workers, cost less. There is a perception that urban workers are more highly paid than their rural counterparts."

"This is not necessarily true. In many cases, rural providers compete with their urban neighbors for patient care and for many skilled workers. In the extreme, some providers often have to pay higher wages to attract skilled employees."

### **Myth No. 3: Rural health care is inordinately expensive**

"As noted previously, Medicare payment formulae recognize costs that are particularly high in urban areas and disregard costs that are particularly high in rural areas. Hence, rural providers, particularly small rural hospitals, seem always on the edge of fiscal collapse. A variety of special payments have been instituted to help them survive, such as payments to sole community hospitals (SCHs), critical access hospitals (CAHs) and Medicare Dependent Hospitals (MDHs). Despite these special provisions, payments per unit of care in rural hospitals remain well below payments to urban hospitals."

"Nevertheless, the need for special payments attracts more attention than the actual payment levels, leading to the perception that rural hospitals, with what otherwise would be seen as very economical operations, are relatively costly and inefficient. Rural advocates argue that the need for special payments reflects problems with Medicare payment formulae rather than rural operations."

### **Myth No. 4A: Rural Medicare beneficiaries don't care about local access to care**

"It is true that many rural people, particularly young people, choose to travel to urban areas for their health care feeling that they will receive higher quality and more confidential care. However, it should be noted that Medicare beneficiaries behave quite differently in securing health care than younger rural residents. Although they have financial access to care wherever they choose to be seen, rural seniors overwhelmingly select local care in preference to remote care."

### **Myth No. 4B: Rural health care needs can be met by urban centers**

"Few would argue that highly complex care should be available in every small town."

"And, as is now widely acknowledged, rates of accidental injury and death are far higher in rural than urban areas. Appropriate care that is received within the 'golden hour' after injury or event is crucial. The Medicare population is also particularly vulnerable to heart attack and stroke. 'Clot-buster' therapy, administered early and appropriately, can prevent devastating damage from evolving heart attacks and strokes. The decision whether to administer this treatment requires immediate access to moderately sophisticated diagnostic equipment and consultation. The consultation and imaging interpretation can be provided through telemedicine technology, but the first-level clinical judgment and diagnostic instrumentation cannot."

"Finally, it should be noted that the likelihood that a person will get appropriate chronic or acute care is related to ease of access. For older patients such as Medicare beneficiaries, transportation to health care is a major access barrier. More rural beneficiaries live in poverty (25% compared to 20% of urban beneficiaries), lack access to public transportation (only 12% of communities with < 2500 people have access to public transportation) and have conditions interfering with activities of daily living than their urban counterparts. Convenient local access to appropriate comprehensive care is important to the health and quality of life of rural Medicare beneficiaries."

## Myth No. 5: Rural America is an idyllic, homogenous, healthy agrarian society

“The typical nostalgic depiction of rural America may be as misleading as any of the myths that have been discussed but may be the hardest to dispel. The reality is that rural Americans are more likely to be poor, old, and experiencing poor health and disabilities than their urban counterparts. They are less likely than their urban counterparts to have access to an automobile or public transportation or to have a telephone. Thus, access to primary medical services is problematic in many rural communities.”

“The rural/urban disparity in mental health and social services is even greater. The rural elderly are less likely than the urban elderly to have private supplemental insurance and more likely to be on Medicaid. The rural elderly who stay in one place as they age are in poorer health than either their urban colleagues or those who relocate upon retirement. Depression and other mental disabilities are equally or more common among rural than urban people, though intervention services are relatively sparse. The rural elderly are also more likely to live alone, far from other family members.”

“Few rural families have any involvement in farming. In 1990 only ten million people (4% of the population) were members of families earning any farm-related income. Only three million, 1.3%, were members earning most of their income from farming. Manufacturing, on the other hand, provides similar proportions of jobs in rural and urban areas.”

“While rural America has fewer members of minority groups than urban areas, it is becoming more diverse. Many agricultural and food processing areas are witnessing rapid growth of their Hispanic populations, particularly in the Midwest and the South. Other communities are hosting new communities of immigrants from Southeast Asia.”

### Summary

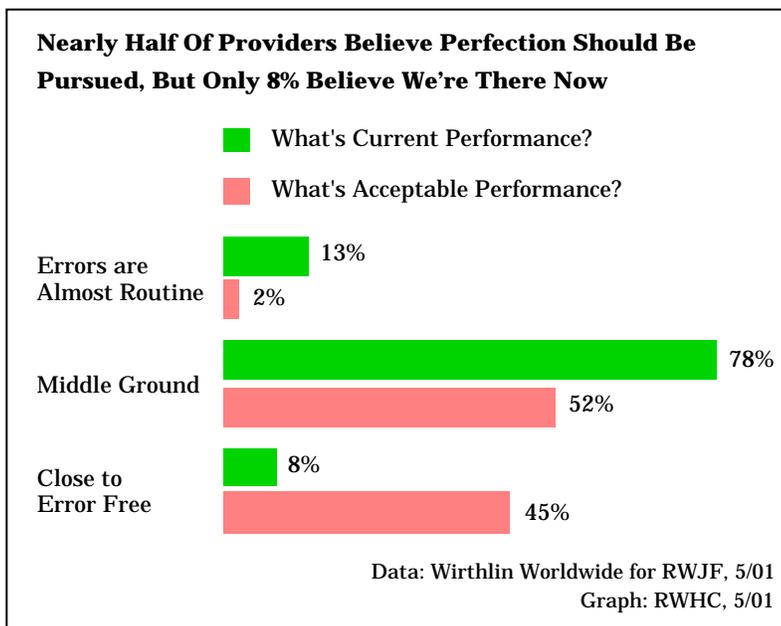
“Simply put, rural America in 2001 may not fit the perceptions that have long been a staple of the public consciousness. These views, both directly and indirectly, have helped shape health policy decisions and not always for the better. As the debate on Medicare reform continues, the Committee believes it is important that policymakers give considerable thought to the 8.1 million rural beneficiaries across the country as they decide how to restructure and improve the Medicare program.”

## Raising The Bar For Provider Performance

From a press release “U.S. Health Care Providers Say Quality of Care is 'Unacceptable' ” by the Robert Wood Johnson Foundation, 5/01:

“Health care providers and administrators believe the quality of health care in America needs to be dramatically improved, according to survey results released by the Robert Wood Johnson Foundation. The nationwide survey of more than one thousand health care professionals shows that more than half (58 percent) of providers and administrators think health care in this country is not very good, with as many as 95 percent of physicians reporting that they have witnessed a ‘serious’ medical error. The need for change is apparent to health care providers who were surveyed, with 4 of 5 stating they believe fundamental changes are needed in the American health care system. The survey results are available at <[www.rwjf.org/](http://www.rwjf.org/)>.”

“The results of the survey were announced during a news conference formally launching a new \$20.9 million initiative. The program, Pursuing Perfection: Raising the Bar for Health Care Performance is funded by the Robert Wood Johnson Foundation and managed by the Institute for Healthcare Improvement. The goal of Pursuing Perfection is to help hospital and physician organizations dramatically improve the quality of health care by pursuing perfection in all of their major health care processes. A working definition of pursuing perfection is striving to:



- deliver services accurately and correctly and at the right time;
- avoid services that are not helpful or cost-effective;
- prevent safety hazards and errors; and
- respect each patient's unique needs and preferences.”

“Despite survey results that indicate low marks from health providers and administrators, Donald M. Berwick, MD, MPP, president and CEO of the Institute for Healthcare Improvement, said he is very encouraged that a significant number of providers (29 percent) believe they personally can be leaders in improving the system.”

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## Success Demands Touch And High Tech

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From “An Interview with Wilbur Arnold, Partner, Deloitte & Touche” in *Health Care Review*, about the latest edition of their annual environmental assessment (in partnership with the VHA), 4/01:

“ ‘Health care plays a fundamental role in the U.S. economy not only in the delivery of health services but also in other ways. National health spending as a percentage of the gross national product is expected to rise steadily in this decade, continuing the trend of the early 1990s. Insurers are reflecting premium increases above the Consumer Price Index,’ Arnold asserts. ‘According to inflation-adjusted statistics, employees paid more than twice as much for health insurance in 1998 as in 1988 and the rise this year is pegged at 11 percent (compared with a 3-percent increase in the CPI). My reading is that insurers are looking to counteract the rising costs of prescription drugs and the increasing demand by consumers for care.’ ”

“ ‘As the population ages, there’s going to be a greater demand for services from a health industry already strained by financial pressures. A major force in the increasing demand for health services is an aging population,’ Arnold points out, ‘particularly the baby boomers.’ ”

“Arnold says the situation is analogous to the need to build schools and hire new teachers to respond to a rising school-age population. ‘Now we are seeing a resurgence in the school system, after having had underutilized facilities. The same thing is happening in health care. After a dramatic shift from acute to ambu-

latory services, the demographics and utilization trends are even pointing to a resurgence in inpatient care.’ ”

“ ‘Eighty-six percent of the reporting hospitals say they have shortages in nursing,’ Arnold states, ‘and many lack ancillary staff as well.’ The need for registered nurses (RNs)—particularly by hospitals—is well-documented. ‘The problem is expected to get worse, faster than for any other occupation,’ Arnold contends.”

“Other staff shortages are also problematic: more than 60 percent of hospitals indicate a need for more ancillary personnel and approximately 50 percent want more nurses’ aides. Licensed practical nurses and information systems rank next, for 35 percent and 31 percent of hospitals, respectively.”

“Given the pressures on the health care industry—financial concerns, demands for services, and staffing shortages—Arnold notes differences between payers’ and providers’ business priorities, according to a survey of the chief executive officers (CEOs) of hospital and insurer organizations. ‘Hospital CEOs put improving consumer satisfaction first, improving quality of care second, and improving profit third. Payers, on the other hand, after several years of disappointing earnings, rising costs associated with expanded benefits, and more consumer choice, are giving first priority to improving their economic positions in order to remain in business, then are focusing on customer satisfaction, and next on quality of care.’ ”

“ ‘Physicians, struggling with their relationships with hospitals and insurers, perceive that the quality of care they provide is worsening,’ Arnold reports. Turning to an area that perplexes both payers and providers: ‘Physicians feel disempowered,’ Arnold says. According to one survey nearly 90 percent are either concerned or very concerned about their futures. A growing number think they are working harder to just stay even relative to income.’ ”

“A survey of internal medicine sub-specialists cited in the edition indicates that over half of them think ‘their ability to provide quality care has gotten worse

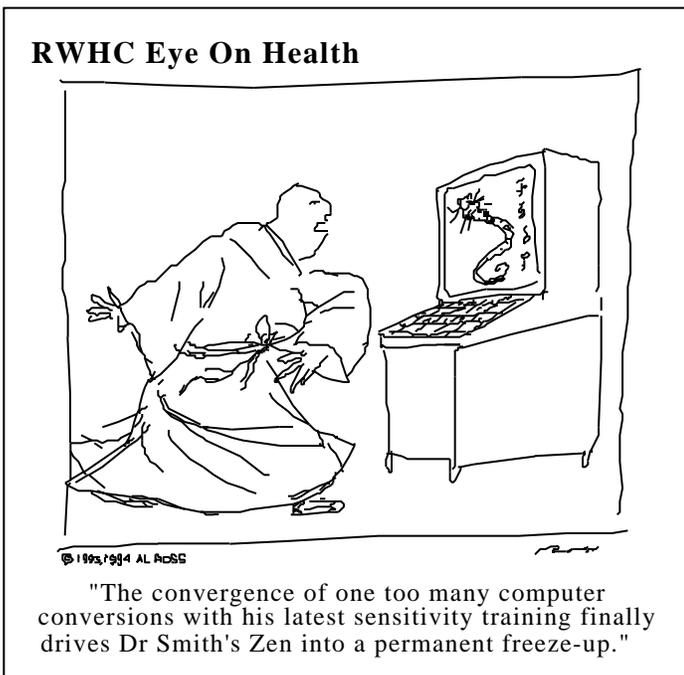
**Wisconsin Youth Apprenticeship Program Health Services Guide** is available as a "pdf" file on the web at [www.rwhc.com/new](http://www.rwhc.com/new). This 48 page "how to" guide was developed by the Rural Wisconsin Health Cooperative and the Wisconsin Health and Hospital Association with sponsorship by the Governor’s Work-Based Learning Board.

in the past five years.’ Less than half of the subspecialists perceive that they can ‘adequately keep up-to-date with new treatment developments.’ Even fewer generalist physicians are satisfied with their ability to keep abreast of health care advances.”

“Reflecting on the trend in the 1990s for hospitals to acquire physician practices, Arnold notes that the situation is much different now. He reports that hospitals’ strategic decisions to divest themselves of physician practices and renegotiate physician relationships—a trend reported a year ago—is more pronounced this year. In his view, the turmoil in hospital-physician relations is resulting in both parties’ worrying about the implications and seeking new ways to relate to each other.”

“The importance of technology in providing health information to consumers figures prominently in this year’s environmental assessment. ‘According to study projections, more than 88 million adults who go online by 2005 will be e-health consumers,’ Arnold asserts. ‘That is a huge increase from the 31 million e-health consumers in 1999.’ ”

“With growing numbers of payers and providers encouraging consumers to go online for health information, the percentage of direct connections (such as for insurance transactions and prescription orders) is also rising. In 1999, nearly three million consumers connected with payers and providers over the Internet. This is anticipated to grow to 55 million by 2005.”



“ ‘Health care organizations will have to adhere to new market-driven rules in order to be successful in the future,’ Arnold advises. Looking ahead five years or so, Arnold suggests that ‘shifting financial mechanisms, changes in demographics and consumer behaviors, and technological differences in consumer access to health information and purchasing’ will put pressure on providers to transform the patient experience. ‘Patients expect hassle-free encounters, person-to-person connection, excellent clinical outcomes, and cost-effectiveness,’ he reports. ‘Moreover, in addition to transforming the patient experience, assuring market growth and financial viability will continue to be important.’ ”

“Summing up the ‘new rules for staying in the game,’ Arnold maintains: ‘We have listed just five of them:

- **We have to stay close to the patient.**
- **We’ve got to foster creativity.**
- **We’ve got to understand that control is an illusion (that is, worry about who is benefiting rather than about who is in charge).**
- **We have to worry about function rather than structure.**
- **We have to make some choices because we won’t always get things to turn out the way we want to.’ ”**

“Arnold contends ‘the organizational structures and delivery models of the 1990s simply won’t work in the future. We can’t fine-tune the old structures—tweak them around the edges anymore. We need to find a whole new organizational delivery model, one we describe in the edition as a *personalized health enterprise model*.’ Three core competencies define the new model, according to Arnold. The first is ‘clinical processes and people, because more satisfied patient care employees drive improved service to patients.’ The second consists of ‘physician relations, because more satisfied physicians drive improved care delivery quality and patient satisfaction.’ The third is comprised of ‘patient/customer-centric services, because more satisfied patients drive improved financial performance.’ ”

“These core competencies rest on a base of non-core functions and operations, some or all of which may be outsourced. ‘New organizational design and skill sets are critically important to the success of the new model. Moreover, we have to pay greater attention to clinical outcomes than we have in the past. Clearly that will impact patient safety which was the recent fo-

cus of an Institute of Medicine report and other studies on medical errors.’ ”

“He adds that ‘it’s also important that virtually everyone who works for the health care delivery setting sees him or herself as an integral member of a team involved in the core competencies of clinical service, physician relationships, and patient satisfaction. Finally—and I’ve saved this to last—IT (information technology) is an enabler. If a health delivery system or a hospital is not able to provide IT effectively, it will, in fact, be out of the ballgame.’ ”

*For more information about HEALTH CARE 2001: A Strategic Assessment of The Health Care Environment in the United States, please call the VHA at 1-800-931-0053. The edition is available for purchase both as a book and as a CD.*

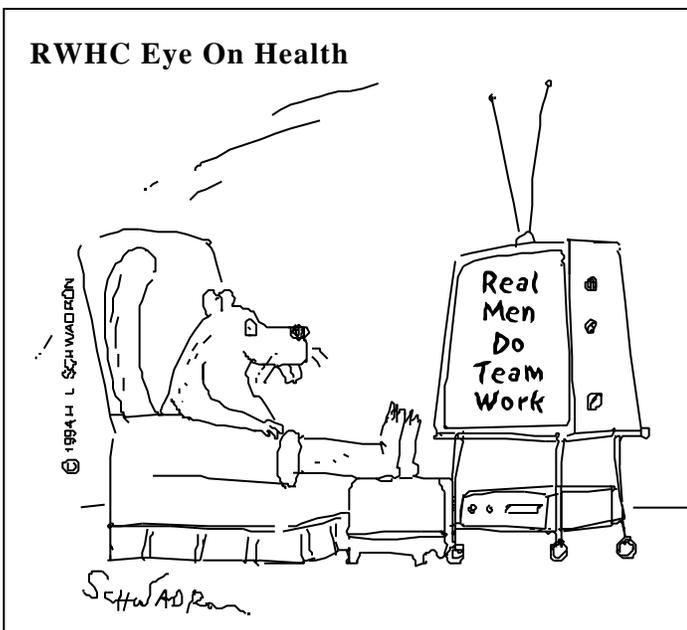
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## In Praise Of The Beaver & Rural Tradition

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From “Working Like Beavers” by John Shepler (book review of *Gung Ho!* by Ken Blanchard and Sheldon Bowles) at <[www.execpc.com/~shepler/](http://www.execpc.com/~shepler/)>, 10/98:

“Andy Longclaw perched cross-legged on the make-shift observation deck, ten feet above the shoreline of the pond. He passed the binoculars to his companion, Peggy Sinclair, and motioned to the water spilling out of the damaged section of the beaver dam. He wanted his boss to see something that could be crucial in saving their failing company. As four brown furry heads poked up from beneath the water, Andy spoke quietly:



‘The Way of the Beaver answers the question: Who is in charge here?’ ”

“The beaver held a sacred place in the lore of Andy's Native American ancestors... A beaver dam may bridge two shores three hundred feet apart. Enos A. Mills, the founder of Rocky Mountain National Park, once measured one on the South Platte River that stretched for 1100 feet. He was fascinated by the industry of the beaver and often observed them as they felled trees and stitched them to make their lodges and dams. In 1909, he wrote it all down in ‘The Beaver and his Works.’ Like Andy Longclaw and Peggy Sinclair, Enos Mills noticed something in the behavior of beaver that we overlook or dismiss as insignificant in our own socialization. At the heart of the way of the beaver is a culture of shared purpose, individual initiative and cooperative contribution that ensures the prosperity of the colony and creates value far beyond the survival needs of the species.”

“There is apparent lack of organization in the way of the beaver, yet each individual ‘knows’ what needs to be done and makes the necessary contribution without prodding, supervision or special incentive plan. The prosperity, indeed the very survival, of the colony depends on this shared sense of mission and the training by observation that is passed down from the elders to the kits during their spring and summer development. By nature, they pick it up quickly. They each have a single season at home, where they help build the dam and a lodge, and stock the pond with tasty branches for the long winter's meal supply. Next spring, they're expected to move on to start their own colonies and make way for the kits to be born here that year. In this way, each individual contributes and benefits, the colony survives and does its good works for nature at large, and the beaver species propagates as it spreads throughout the land.”

“Perhaps we've forgotten the lessons we once knew as natives upon the land or even as pioneer farmers. A barn raising is not all that unlike the building of a beaver lodge. The community assembles on the chosen spot, each individual with the know-how to cut the board and assemble the structure. With little fuss they form into groups and begin to simultaneously raise the frame, then nail the roof and sides. Within a day, a barn rises on the land and may stand solidly for fifty to a hundred years. Next year, it is someone else's turn to benefit.”

“Andy Longclaw draws a parallel between the self-directed behavior of the beaver and the factory work teams that exhibit a ‘Gung Ho’ spirit in accomplishing their missions. The secret lies in unleashing the inherent motivation we all have for deriving satisfac-

tion in contributing to a worthwhile effort. It is a spirit that is often nurtured in sports teams, exhibited by hobbyists and volunteer groups, and arises spontaneously in the play of children. It is the enthusiasm that is often destroyed by mean spirited or selfish intentions on the part of those who lead by authority and directive. The illusion of control is that you can manipulate the spirit as well as the hands, or the motions of a machine. True accomplishment comes from a collective sense of purpose working toward a shared goal.”

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## Warm Hearts Build Healthy Bodies

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The following is by the Dalai Lama, written as a Forward to *The Longevity Code* by Dr. Zorba Paster, a keynoter at the recent annual meeting of the Wisconsin Rural Health Association:

“In *The Longevity Code*, Dr. Paster refers to the five spheres of influence in our lives and the importance of finding a balance among them. While it is becoming increasingly obvious that material success alone does not provide genuine happiness, it is also true that without mental peace, mere physical good health is insufficient. The importance of generating a warm heart and behaving with kindness and compassion toward others is that those qualities bring us inner peace. According to Dr. Paster’s findings, they increase longevity as well. This makes sense to me, since I believe that inner peace is definitely of benefit to good health.”

“All of our actions have consequences. Dr. Paster has found that our positive and negative actions, whether they are physical, mental, social, material, or spiritual, have a direct consequence on both the quality and duration of our lives. He suggests that you are not a completely healthy person if you pay attention only to your physical well-being.”

“This is not so surprising for in my experience, when, for example, we develop the ability to patiently forbear with frustrating situations, we find that we develop a proportionate reserve of calmness and tranquility. We tend to be less antagonistic and more pleasant to associate with. This, in turn, creates a positive atmosphere around us so that it is easy for others to relate to us. And being better grounded emotionally through the practice of patience, we find that not only do we become much stronger mentally and spiritually, but we also tend to be healthier physically. Certainly I attribute the good health I enjoy to a generally calm and peaceful mind.”

“On the other hand, not only do negative thoughts and emotions destroy our experience of peace, they also undermine our health. In the Tibetan medical system, anger is a primary source of many illnesses, including those associated with high blood pressure, sleeplessness, and degenerative disorders—a view that seem increasingly accepted in allopathic medicine.”

“I am sure that readers of this book will find much to encourage the development of what I think of as our basic human qualities of kindness, compassion, and a warm heart. If we put these into practice, not only will we find a greater sense of calm and happiness in our day-to-day lives, but also the hope that we can live longer too, as Dr. Paster offers.”

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## Lessons From The For-Profit Networks

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From “Group Versus Group: How Alliance Networks Compete” by Benjamin Gomes-Casseres in the *Harvard Business Review*, 7-8/94:

“Because even pioneers in the field are still learning how to initiate, build, and manage networks of alliances, much of what they are learning is specific to their own experience. Still, a few general lessons have emerged.”

**“Groups are only as strong as the alliances within them: manage individual relationships carefully.** There is no shortcut to designing and implementing partnerships. Even when no new money is being spent, the task requires the same depth of analysis that managers typically apply to major investment decisions. (See Rosabeth Moss Kanter, ‘Collaborative Advantage: The Art of Alliances,’ *HBR*, July-August 1994.)”

**“Effective groups are worth more than the sum of the alliances within them: manage the group as a whole.** Anything less than explicit group management constitutes a lost opportunity to create competitive advantage. Opportunity costs can turn into real costs if a network is left untended and uncultivated.”

**“The sky is not the limit in alliance groups: expand with caution.** The pressure to forge links with new partners is often great, particularly when one’s competitors are doing so daily. However, beware of falling prey to a faddish exuberance. Expand an alliance network only when it makes strategic sense. Even then, do so with the organizational constraints mentioned above in mind.”

**“Where you sit in which network determines what you get: position your company strategically within and among alliance groups.** This is the essence of network competition. Managers need to pay attention to both group- and company-based sources of competitive advantage.”

**“A lack of commitment is the flip side of flexibility: be sure that the network strategy is sustainable for your company.** Alliance groups can fall apart just as rapidly as they are formed. When rivalry among networks is great, competitors will think nothing of picking off the members of a network teetering on dissolution.”

“Managers who follow these guidelines will avoid some of the pitfalls of their predecessors. And their experiences, in turn, will help refine old ideas and develop new ones about how to manage competition among groups.”

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### RWHC Hospital 1<sup>st</sup> As Exemplary Employer

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Congratulations to the Memorial Community Hospital in Edgerton for receiving a Governor’s Exemplary

Employer Award in “recognition of special commitment to progressive employment practices and excellence in expanding employment opportunities.” MCH was nominated because of its successful partnership with Blackhawk Technical College and the Edgerton School District. This longstanding RWHC member is the first hospital, urban or rural, to ever receive a Governor’s Exemplary Employer Award, now in its fifth year.

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### Student’s “Life In the Box” Awarded \$1,000

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The winner of RWHC's Ninth Annual Hermes Monato Essay Prize for \$1,000 is April Eddy for "Life in the Box." April is currently working towards a Master of Science in Nursing. Students of the University of Wisconsin-Madison, who are associated with the Center for Health Sciences are invited to write on a rural health topic for a regular class or on their own and submit it as an entry by April 15th of each year.

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**No July Issue Of *Eye On Health***--Due to the annual editorial staff expedition, the next newsletter will be distributed for August 1<sup>st</sup>.

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