# RWHC Hospital Trustee Manual

**RWHC Eye On Health**

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"No. Around here, I've never heard of any rural backwater or Lake Wobegon."

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Submitted by Tim Size

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**RWHC Ground Rules**

Everyone Participates—**No One Person Dominates**
An Individual's **Silence Will be Interpreted as Agreement**
Listen as an Ally—**Work to Understand Before Evaluating**
Helps to **Assume Positive Intent** First When Things Go Wrong
Please **Minimize Side Conversations**


**RWHC Parliamentary Rules**

**Point of Personal Outrage**–"At any time during a meeting when a participant becomes extremely upset, he or she shall have the right to interrupt any other speaker, will not be required to wait for recognition from the Chair, and has the obligation to speak at a volume considerably higher than required for normal conversation."

**Point of Irrelevant Interjection**–"Irrespective of the motion on the floor, the participant shall have the right to monopolize the meeting for not more than five minutes as he or she discourses on a point the relevance of which escapes all other participants."

**Point of Personal Attack**–"In response to a point raised by another speaker, the participant shall have the right to reply by launching a personal attack on that speaker. At no time shall the point itself be addressed."

**Point of Associative Dismissal**–"The participant shall have the right to impugn the integrity, intelligence, or insight of anyone else in the meeting based solely on her or his association with someone the speaker does not like."

**Pointless Point**–"Entitles the participant to tell those in the meeting something everyone already knows."

[*attributed to Richard Hirsh, the executive director of the Reconstructionist Rabbinical Association in Pennsylvania].

**Responsibilities and Liabilities of Non-Profit Directors**

**Quarles & Brady LLP**

**Hospital Legal Organization**

- Most rural hospitals in Wisconsin are organized as private non-stock, non-profit corporations under Chapter 181 of the Wisconsin Statutes.

- These organizations fulfill their charitable purposes through the rendering of health care services.

- A few hospitals remain essentially an internal division of municipal government and are not separately incorporated.

- This outline addresses the duties and responsibilities of boards of Chapter 181 non-profit corporations providing health care services.

**Corporate Law Principles**

Corporate law principles generally applicable to corporate directors are also generally applicable to hospital boards. However, hospital boards have additional responsibilities, which reflect the services that hospitals provide.

**Two Types of Not-For-Profit Corporations in Wisconsin**

Not-for-profit corporations in Wisconsin are of two types: Membership and Non-Membership.

- "Membership" organizations allocate certain responsibilities to the membership and certain responsibilities to the board.

- "Non-membership" organizations are generally governed by self-perpetuating boards and have no members. Therefore, all corporate authority is vested in the Board.

**Board of Directors is Managing Entity**

For both membership and non-membership organizations, the board of directors is the managing entity of the corporation. It is responsible for establishing corporate policy and supervising its implementation and execution.

**Specific Responsibilities Unique to Health Care Facilities**

- Hospital boards have specific responsibilities unique to health care facilities.

- Specific responsibilities are imposed on hospital boards by:

- Federal and state laws, regulations, and common law
- Accreditation agencies such as The Joint Commission (TJC)
- Third-party payor programs

## Responsible for Medical Care

Pursuant to law and regulations, hospital boards are ultimately responsible for the medical care provided by the organization. Hospital boards execute their authority by delegating functions to specific parties.

## Fiduciary Duty

Hospital boards have a fiduciary duty to the institution. Board members have a "Duty of Care" and a "Duty of Loyalty" to the corporation.

- The Duty of Care

  - The "Duty of Care" requires that a director be informed and discharge his or her duties in good faith, with the care that an ordinarily prudent person in a like position would reasonably believe appropriate under similar circumstances.

  - Director obligations with respect to the duty of care arise in two contexts:

    - *The decision-making function*: The application of duty of care principles to a specific decision or a particular board action; and

    - *The oversight function*: The application of duty of care principles with respect to the general activity of the board in overseeing the day-to-day business operations of the corporation; i.e., the exercise of reasonable care to assure that corporate executives carry out their management responsibilities and comply with the law

  - How to satisfy the duty of care:

    - Know and understand your governing documents
    - Attend meetings
    - Exercise independent judgment
    - Stay adequately informed
    - Properly oversee any group or individual to whom the board has delegated certain functions
    - At bottom, satisfying the duty of care is about *procedure*. Were all directors free of conflicts of interest in reaching the decision in question? Did the directors insist on data? Did the directors put forth the time and resources reasonably necessary to reach the decision in question?

- The Duty of Loyalty

    - The "Duty of Loyalty" requires that directors act in the best interests of the corporation rather than in the interests of themselves or another entity.  A director cannot use a corporate position for individual personal advantage.

    - Directors must fully disclose direct and indirect conflicts of interest

        ▪ A conflict of interest is present whenever a director has a material personal interest in a proposed contract or transaction to which the corporation may be a party

    - Before engaging in a transaction that may be of interest to the organization, a director should disclose that transaction to the Board of Directors.

        ▪ The director may be obligated to offer a business opportunity to the corporation before taking advantage of such an opportunity outside his or her capacity as a director.

    - A director should treat all matters as confidential until they have been publicly disclosed or they become a matter of public record.

    - Directors who are personally involved in an excess benefit transaction may be subject to a penalty tax.

        ▪ For example, if a director participates in a transaction with the exempt organization in which the economic benefit gained by the disqualified person exceeds the consideration that she or he provides to the exempt organization, the transaction is an excess benefit transaction.

## Liability Issues & Protection for Directors

- Directors who satisfy their duty of care are entitled to the protection of the business judgment rule.  This means that as long as the director exercises his or her duty of care appropriately, in good faith, he or she is entitled to the rebuttable presumption that he or she has exercised the duty of care, and directors will not be held liable for losses to a corporation resulting from board decisions.  This standard has been developed by the courts to allow directors freedom to make business decisions without fearing future liability for honest errors in judgment.

- Section 181.0855 of the Wisconsin Statutes limits the liability of directors and officers of Wisconsin non-profits.  Specifically, a director is not liable to the corporation or other third parties for a breach of duty *unless* the breach constitutes any of the following:

    - A willful failure to deal fairly with the corporation or its members in any matter where the director has a material conflict of interest.

- A violation of criminal law, unless the director or officer had reasonable cause to believe that his or her conduct was lawful or no reasonable cause to believe that his or her conduct was unlawful.

- A transaction from which the director or officer derived an improper personal profit or benefit.

- Willful misconduct.

- Sections 181.0871 through 181.0889 of the Wisconsin Statutes provide for certain indemnification rights for directors and officers of non-profit corporations.

- The existence of conflict of interest policies can help avoid IRS sanction. The policies must require disclosure by any director who has a direct or indirect financial interest in any transaction or arrangement with the organization.

- Insurance is available that can extend beyond statutory indemnification protections. Some claims are not indemnifiable but may be insurable.

## Areas of Special Sensitivity

- Stark Law - Physician Self-Referrals

  - If a physician has a "financial relationship" with an entity, the physician may not make a referral to the entity for the furnishing of "designated health services" for which payment may be made from Medicare or Medicaid.

  - Sanctions for violation include denial of payment for services; repayment of amounts collected; civil penalties; exclusion from participation in federal health care programs.

- Anti-Kickback Statute

  - The anti-kickback statute provides for criminal penalties and/or exclusion for anyone who knowingly and willfully solicits or receives financial incentives in return for business reimbursable by a public health care program.

- Medical Staff Relationships

  - Medical Staff Recruitment and Credentialing

    - The governing board is responsible for oversight of the medical staff, including the process for credentialing and delineating privileges.

- There are numerous sources of potential liability for all involved in the credentialing process.
- Suggestions:
  - Work with the hospital administration to develop a physician recruitment plan, updated frequently to reflect physician needs. Also, have an established system for carrying out the board's duties with regard to credentialing and re-credentialing.

- Financial Relationships with Physicians

  - Suggestions:
    - Have a written agreement with a term of at least one year
    - Provide fair market value compensation
    - Compensation cannot be based on volume or value of referrals

- Tax-Exempt Status

  - Private Inurement
  - Public Benefit
  - Unrelated Business Income

- Fraud and Abuse

  - The Office of Inspector General (OIG) has the ability to exclude individuals and entities from participating in federally-funded health care programs (i.e. Medicare and Medicaid).

  - Exclusion actions can be taken in response to program-related fraud and abuse, patient abuse, defaults on Health Education Assistance Loans, and licensing board actions.

- Anti-Trust

  - Anti-trust is based on the premise that competition is good, and agreements that reduce competition can be bad, resulting in increased costs to consumers.
  - Anti-trust concerns can arise in the following health care contexts:
    - Joint ventures or mergers
    - Non-compete agreements
    - Offering payors bundled or packaged discounts
    - Price-fixing, per se anticompetitive conduct

# Board Self-Assessment Guide

An evaluation of hospital governing board performance

# Table of Contents _____

# Introduction_____

This material has been prepared by the Iowa Hospital Association Council on Education and Member Services for hospital trustees. The Council is composed of hospital trustees and chief executive officers and has undertaken the preparation of this self-assessment document as a means to strengthen the governance function. Effective boards of trustees were never more important to hospitals than they are now. Self-evaluation is an important tool to be used to improve board effectiveness. We hope this document will further serve that purpose.

# Why Self-Assessment_____

In this era of health reform and major changes in the health care delivery system, health care organizations are being challenged as never before. In many cases, external forces loom as a serious threat to institutional viability. Boards must be prepared to meet these challenges and to continue serving the needs of their communities. Self-assessment is a tool for boards to utilize to ask themselves how well they are prepared to meet these challenges.

Self-assessment can help show a board where its strengths lie as well as where improvement may be needed. It is an important function that should be an ongoing part of serving on any Iowa hospital or system board.

# Guidelines for Effective Boards _____

The role of a health care governing board is to ensure that the hospital and/or system provides high-quality, affordable care which meets community and area needs.  To carry out this role, governing boards need to effectively deal with several responsibilities, including:

A.  Establishing a mission and vision for the organization and approving goals, objectives and policies with a system for monitoring their implementation.

B.  Accountability for quality of care provided to meet this legal and moral responsibility the governing board must:

- Establish and maintain effective medical staff credentialing;
- Establish and maintain an effective system for quality control;
- Establish a hospital and system-wide, total quality control system.

C.  Ensuring adequacy of funding both for current operations and future needs.  Boards are responsible for reviewing and approving annual budgets, monitoring investment of monies not needed for day-to-day operation, raising capital for improvements and managing endowments.

D.  Planning for the future successful operation of the hospital/system requires development of a hospital strategic plan.  In today's environment, planning requires assessment of community needs and services, assessment of the organization's capabilities and coordination with other health facilities and providers to develop a community based care network and integrated delivery systems that can function effectively in the current environment.

E.  An effective communications program where hospital/system policy and operations are understood by the citizens, community leaders and local government.  The board should represent the organization to its communities and recognize the need to influence the broader political and economic environment in which the organization operates.

F.  Assuring that the organization is effectively managed through:
- Recruitment, selection and retention of the best possible CEO;
- Clear understanding of the roles of governance and administration;
- Provision of adequate supplies, facilities, equipment and personnel to do an effective job.

G.  Ensuring the effective function of the board through:

- Working together as a board by addressing issues using established policies and procedures.
- Recruitment of interested, hard working members;
- Comprehensive orientation for new members;
- A planned program of continuing education for all board members;
- Self-assessment to determine strengths and weaknesses.
- Board succession planning.

# How to Use These Materials _____

Self-assessment should become a recurring process with a formal assessment performed at least once a year.  Boards should review the goals, mission statement and strategic plan of the hospital prior to beginning the self-assessment.  **Boards should tailor the questions included in this assessment as needed to fit their particular hospital/system.**  However, questions that relate to the organization's strengths and those of its board members should not be omitted; it is as important for the board to be aware of its strengths as well as its deficiencies.

The value of this self-assessment depends to a large degree on the ability and willingness of the participants to be open and realistic as they answer the questions.

Boards should be prepared to take a hard look at their past performance, and based on what they see, be prepared to take steps to change their procedures, structure or composition to improve performance.

Following completion of the questionnaire by each board member, the questionnaire should be returned to the CEO, board chair, board committee chair, or outside consultant for tabulation and preparation of a report to the board at its next meeting.  The meeting agenda should provide time for discussion and analysis of the results and preparation of plans to address areas that indicate need for improved performance.  Future action may well include educational programs addressing needs identified.

# Board Self-Assessment _____

The following two-part evaluation tool has been designed to help boards and board members to identify their strengths and weaknesses.  The first part consists of a series of questions that evaluate the whole board.  **If you are not sure of an answer, please leave it blank.**  Part two is a short personal assessment for each member of the board.

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# Full Board Evaluation_____

Section 1

**Some of the questions do not apply to all hospital boards due to statutory requirements. In those instances, please mark "question does not apply."** While a "yes" or "no could answer some of these questions" we believe it is important to ascertain the feeling of the board on these subjects. Therefore, we ask that you use the scale provided.

Using the following definitions of levels of performance, please indicate below your perceptions and evaluations of the Board's work performance. Mark only those categories you feel able to evaluate board performance. Feel free to make additional written comments.

| | |
|---|---|
| 1 | Strongly Agree |
| 2 | Agree |
| 3 | Disagree |
| 4 | Strongly Disagree |
| 5 | No opinion |
| 6 | Question does not apply |

STRONGLY AGREE AGREE DISAGREE STRONGLY DISAGREE NO OPINION DOES NOT APPLY

## Board Composition

**1  2  3  4  5  6**  1. Recognizing statutory requirements, the board consists of a workable number of members (no more than 15) to function effectively and efficiently as a group.

**1  2  3  4  5  6**  2. Board membership is reflective of the makeup of the community being served with needed professional skills/talents and appropriate racial and gender mix.

**1  2  3  4  5  6**  3. If legally permissible, the chief executive officer (CEO) should be a member of the board.

**1  2  3  4  5  6**  4. If legally permissible, the board should include one or more medical staff members.

**1  2  3  4  5  6**  5. Prospective board members are identified by a nominating committee or through

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another organized succession planning process.

**1  2  3  4  5  6**   6. The legal responsibilities and the potential liabilities of governance are clearly spelled out to board members.

**1  2  3  4  5  6**   7. Board members regularly attend board meetings in order to conduct business and make informed decisions.

**1  2  3  4  5  6**   8. Board members are protected against the potential liabilities of governance through indemnity arrangements, insurance and other measures.

**1  2  3  4  5  6**   9. Board members are appointed for a specified period of time with provision for reappointment, and with a limit on the number of terms.

**1  2  3  4  5  6**   10. Board members are required to disclose possible conflicts of interest before their appointment and periodically throughout their terms as trustees.

## Support for Trustee Education

11. The board provides opportunities for development through:

**1  2  3  4  5  6**   a. A formally established program for orienting members.

**1  2  3  4  5  6**   b. Continuing education sessions for all board members, including discussions of local and national hospital issues.

**1  2  3  4  5  6**   c. Reimbursement of expenses for local, state and national conference and seminar attendance.

**1  2  3  4  5  6**   d. Subscriptions to periodicals on health care management and trusteeship.

**1  2  3  4  5  6**   12. Members are encouraged to identify areas where further board education is needed or in which additional information would be helpful.

## Board and Committee Procedures

**1  2  3  4  5  6**   13. The hospital/system has one or more statements/documents that are periodically reviewed and revised that identify the hospital's/system's direction and role (e.g., mission, vision, values, philosophy statements).

**1  2  3  4  5  6**   14. The board has a written set of bylaws that are periodically reviewed.

| STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE | NO OPINION | DOES NOT APPLY | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 15. The roles, responsibilities, functions, relationships and authorities of the board members and officers, the CEO, and the medical staff are in a written statement (e.g., bylaws, policy, job descriptions, and procedures). |
| 1 | 2 | 3 | 4 | 5 | 6 | 16. The board conducts business using formal procedures, such as "Robert's Rules of Order". |
| 1 | 2 | 3 | 4 | 5 | 6 | 17. Board meetings are scheduled at appropriate intervals. |
| 1 | 2 | 3 | 4 | 5 | 6 | 18. The length of board meetings is realistic and based on planned agendas. |
| 1 | 2 | 3 | 4 | 5 | 6 | 19. The board has the necessary information to arrive at responsible decisions. |
| 1 | 2 | 3 | 4 | 5 | 6 | 20. The board conducts its deliberations in a thoughtful and objective manner. |
| 1 | 2 | 3 | 4 | 5 | 6 | 21. The bylaws provide for a committee structure with board member participation allowing the board to fulfill its responsibility. |
| 1 | 2 | 3 | 4 | 5 | 6 | 22. Standing and ad hoc committees report regularly to the full board. |
| 1 | 2 | 3 | 4 | 5 | 6 | 23. Committees are reviewed annually with regard to composition, goals, responsibilities and performance. |

## Scope of Responsibility

| STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE | NO OPINION | DOES NOT APPLY | |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 24. The board exercises its authority to make those policy and other decisions that the board should make. |
| 1 | 2 | 3 | 4 | 5 | 6 | 25. The board effectively fulfills its responsibility for establishing and maintaining the organization's long-range or strategic plan. |
| 1 | 2 | 3 | 4 | 5 | 6 | 26. The board reviews the organization's financial position on a regular basis, using budget reports and other documents in order to ensure long-range financial stability. |
| 1 | 2 | 3 | 4 | 5 | 6 | 27. A performance evaluation of the CEO is done annually. |
| 1 | 2 | 3 | 4 | 5 | 6 | 28. The board has policies, a process and guidelines for reviewing and approving contracts for all professional services. |

**1   2   3   4   5   6**    29. The board makes informed decisions on medical staff appointments, reappointments and clinical privileges and fulfills its responsibility for a properly functioning medical staff.

**1   2   3   4   5   6**    30. The board effectively monitors and evaluates all areas of performance, including quality of care.

**1   2   3   4   5   6**    31. The board refrains from making decisions related to the implementation of policy that should be made by the CEO and management staff.

**1   2   3   4   5   6**    32. The board refrains from making decisions related to the implementation of policy that should be made by the medical staff.

**1   2   3   4   5   6**    33. The board seeks opportunities to communicate with the community regarding hospital/system services and programs and to inform and seek input to determine unmet health care needs.

**1   2   3   4   5   6**    34. The board effectively represents the hospital/system in the political arena, influencing the decision-making process.

**1   2   3   4   5   6**    35. The board actively participates in the fund-raising and development program.

**1   2   3   4   5   6**    36. The board receives an accurate record of deliberations made during its meetings through the timely distribution of minutes.

**1   2   3   4   5   6**    37. Board members receive meeting notices, written agendas with appropriate materials well in advance of meetings.

**1   2   3   4   5   6**    38. Background material is supplied early enough for study before board meetings.

**1   2   3   4   5   6**    39. Board members routinely receive relevant hospital/system publications, such as magazines, newsletters, bulletins, press releases, brochures and announcements.

**1   2   3   4   5   6**    40. The board has adopted a policy and process to manage and reduce risk.

**1   2   3   4   5   6**    41. The board receives sufficient status reports on the implementation of board actions and decisions.

**1   2   3   4   5   6**    42. The board has established an effective means to promote open communications between the board, medical staff and hospital staff.

**1  2  3  4  5  6**  43. The board receives feedback from the elected or appointed head of the medical staff on the implementation of board decisions affecting the medical staff, and generally shares information, ideas or concerns with the board.

**1  2  3  4  5  6**  44. To facilitate communication among the board, the administration and the medical staff, various means are used such as:

**1  2  3  4  5  6**    a.  The President of the medical staff attends board meetings.

**1  2  3  4  5  6**    b.  A joint conference committee.

**1  2  3  4  5  6**    c.  Medical staff membership on board committees.

**1  2  3  4  5  6**    d.  Administrator and trustee attendance at medical staff meetings.

**1  2  3  4  5  6**    e.  Board membership on medical staff committees.

**1  2  3  4  5  6**    f.  Exchange of board minutes and medical staff minutes.

**1  2  3  4  5  6**    g.  Special ad hoc committees formed to deal with issues affecting the board, administration and medical staff.

Comments: _____

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# Personal Evaluation _____

## Section II

| How Satisfied Are You That You | VERY SATISFIED | | | | VERY DISSATISFIED |
|---|---|---|---|---|---|
| Understand the organization's mission? | 1 | 2 | 3 | 4 | 5 |
| Have a positive working relationship with other board members and with the CEO? | 1 | 2 | 3 | 4 | 5 |
| Are knowledgeable about the organization's major programs and services? | 1 | 2 | 3 | 4 | 5 |
| Follow trends and important developments in health care? | 1 | 2 | 3 | 4 | 5 |
| Understand the organization's budget process and are knowledgeable about how funds are spent? | 1 | 2 | 3 | 4 | 5 |
| Prepare for, attend and participate at board meetings, as well as other activities of the organization? | 1 | 2 | 3 | 4 | 5 |
| Take advantage of opportunities to enhance the organization's public image by periodically speaking to leaders in the community about the work of the organization? | 1 | 2 | 3 | 4 | 5 |
| Suggest agenda items for future board meetings? | 1 | 2 | 3 | 4 | 5 |
| Advise and assist the organization when your help is requested? | 1 | 2 | 3 | 4 | 5 |
| Participate in outside educational opportunities to remain current on changing health care issues and trends? | 1 | 2 | 3 | 4 | 5 |
| Understand the confidential nature of board deliberations and maintain privacy regarding issues and information discussed in board meetings? | 1 | 2 | 3 | 4 | 5 |
| Find serving on the board to be a satisfying and rewarding experience? | 1 | 2 | 3 | 4 | 5 |

|  | VERY SATISFIED | | | | VERY DISSATISFIED |
|---|---|---|---|---|---|
| Avoid in fact conflicts of interest. | 1 | 2 | 3 | 4 | 5 |
| Understand the function, role and responsibilities of being a board member. | 1 | 2 | 3 | 4 | 5 |

Comments/Feedback: _____

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Name (optional) _____

**Ensuring High Quality Care**
by Beth Dibbert, RWHC Quality Consultant

When asked to describe "quality healthcare", you might bring to mind your personal stories. Your stories could contain healthcare heroes – those providers that provided exemplary care for you or someone you care about, and could also contain mis-steps or mistakes that were made by person or a process that delayed or complicated care. Each of us has a healthcare history, and that is what we are likely to draw from when asked to describe what "good" care is.

This section is intended to give you a primer on what you need to know to help you be an effective and informed trustee. We have learned that quality is in continual evolution and while you are serving the hospital as a trustee and as a healthcare consumer, you will be learning more.

In 2001, the Institute of Medicine (IOM) published a book called _Crossing the Quality Chasm: A New Health System for the 21st Century_. In it, the IOM identified six characteristics of high-quality care, which have been adopted by other organizations active in improving patient safety and quality care. The care we give must be safe, effective, equitable, efficient, timely, and patient-centered. At the time the list was published it was estimated that over 98,000 deaths occurred in hospitals due to failures and errors, and over 7,000 were attributed to medication errors alone.

While many hospitals and physicians were incredulous, others embraced the opportunity to begin to work together to make our nation's patients safer. Public and private stakeholders became educated in healthcare delivery processes and outcomes that were previously assumed too complicated and proprietary for the common consumer to understand. The Center for Medicare and Medicaid Services (CMS) began requiring hospitals to submit quality data and then made that data available for public use in comparing hospitals in quality performance. Insurance companies began including quality performance data as part of their reimbursement negotiations and contracting. Most importantly, patients themselves became more astute about what to expect from their physicians and hospitals.

As hospitals and physicians began to engage in making healthcare safer, they discovered that the majority of errors and failures were caused by poorly designed systems and processes. For instance, abbreviations that were used by physicians in ordering medications were being misinterpreted by others in the medication delivery and administration process, causing medication errors and omissions. Equipment that delivered intravenous fluids were designed so that a flow valve could be easily and unintentionally opened to full-bore without an alert to the nurse. Wrong-side surgeries were being done because everyone assumed that the surgeon knew what side of the patient was to be operated on. Each of these are consequences of systems that were designed to fail.

So, hospitals became busy finding out what other industries were doing to prevent harm. You only need to visit a Home Depot or gas station to find endless examples of end-user safety engineering: break-away gas hoses, two hand miter saws, etc. The next time you ride an airplane, think about the changes that have taken place in the past ten years or so (both for security and safety).

The healthcare industry had a lot to learn. What we discovered is that we had accepted the risk of harm as operational. That is, medication or surgical errors or healthcare-acquired infections were accepted as part of the risk we take in the complexity and volume of the work we do in modern hospitals. Hospital safety experts began to tackle the riskiest processes first. A list of "unapproved" abbreviations was published, banning the most confusing from medical records. Look-alike medications were identified and re-engineered to reduce the risk of medication mix-ups. A pre-procedure verification (called the "Time Out"), including all of the surgical team verbally agreeing about which part of the patient's body was going to be operated on, was adopted as "best practice" in the operating room. Once published studies confirmed that these and other safety-engineered improvements were reducing errors and saving lives, CMS (the nation's largest health insurer) and other accreditation bodies like The Joint Commission started mandating these changes and improvements.

Still, with all of these and more changes and improvements, statistics showed that the healthcare delivery system was not increasing patient safety. More volume and complex care, as well as the advent of the electronic healthcare record were presenting new challenges. An accelerated pace was needed. Healthcare needed to get better, quicker. CMS and other insurers decided that hospitals need to report more data, and other sources of data like claims and infection data would be helpful in determining whether the best practices that were being determined and established were actually being delivered at the point of care: the patient's bedside.

Currently, CMS requires almost 100 points of data be reported to them, either administratively through claims or by hospital reporting. Those data address the following areas:

- Clinical Quality Care Measures
    - Heart Attack
    - Heart Failure
    - Pneumonia
    - Surgical Infection and Blood Clot Prevention
    - Stroke
    - General Patient Blood Clot Prevention
    - Emergency Department Throughput Timing
    - Immunizations
    - Outpatient Care
- HCAHPS – Patient Satisfaction Surveys

- Claims data that identifies Healthcare Acquired Infections and Readmissions

The data is used for public reporting on CMS' "Hospital Compare" website (www.HospitalCompare.gov) and for hospitals that are paid under the Prospective Payment System (PPS), data submission is required for calculation of the Value-Based Purchasing Program and to avoid a 2% Medicare reimbursement penalty. For Critical Access Hospitals (CAHs) data reporting is still voluntary and there is neither a financial incentive nor penalty; however, Federal Law could change this at any time.

In Wisconsin, the Wisconsin Hospital Association hosts our state's own public reporting quality website called "Checkpoint" (www.whacheckpoint.org). There you can easily compare hospitals within our state on metrics that are extricated from Hospital Compare.

What is the role of data? There is a well-known adage among quality professionals, "You can't improve it if you can't measure it." In rural hospitals, smaller volumes of data present a special challenge in assessing the current state of quality. That challenge extends to the analysis of your performance compare to those of other hospitals in the state or nationally. "Benchmarks" are a standard, or set of standards, used as a point of reference for evaluating performance or quality. State and national benchmarks are generally comprised of similar metrics, but from all sizes and types of hospitals.

Let's say your hospital, in one month's time has a total of five patients who come to the emergency department with a chief complaint of chest pain. These patients are transferred to an acute care hospital for further treatment. We measure whether or not these patients received aspirin at arrival – a broadly recognized best practice. Let's say that for one of those patients, there is no documentation that the patient received aspirin at arrival. Your performance rate for that month is 80%, which is currently below the state average. However, in a larger hospital that one "failure" in a larger volume of eligible patients may affect that hospital's performance rate only minimally. Statisticians can use special calculations that factor in small data to prove a significant trend, but low volumes make benchmark comparisons difficult and easy to explain away.

We have proposed that low volume data presents an advantage to hospitals. Lower numbers of patients should help zero-defect processes and best practices to become "etched" in stone so that misses are rare. In the case of the patient who has no documentation of aspirin at arrival, the drill down and root cause analysis is easier.

Above all, it is your job to ask the right questions of the executive staff and provide informative answers to your stakeholders–the community. When you ask, "Are our patients getting the right care at the right time and in the right place," it is important that the answers you receive can be shown in both narrative and data forms. Continue to ask "why" until you are satisfied that you can relay that same information to those you encounter in the community.  Know the locations of your publicly reported quality data so that you can supplement anecdotal stories with factual analysis.

# Financial Stewardship

### Richard A. Donkle, CPA
### Rural Wisconsin Health Cooperative

## Financial Operating Philosophy

- Long-Term Objectives for Financial Performance.  These objectives set the overall philosophy for obtaining the goals of the hospital.  Determining these objectives should include:  consideration for debt covenant compliance, using debt vs. equity to finance additions, setting investment criteria, the role of fund-raising in the community and the future needs of the organization.

- Profit from Operations.  The board needs to establish an overall standard for profitability for the hospital.  This level of profitability may be determined by using industry comparisons, past historical performance, or other information available to the board.

- Charity Care.  In fulfilling its community service, obligation, the board needs to consider its position on charity care.  It is also a requirement of the Wisconsin Office of Health Care Information that each hospital have an uncompensated care policy.  The board needs to consider their charity care plan in determining their desired level of profitability.

- Employee Compensation.  The board should consider total compensation which includes wages, fringe benefits, etc.  They should also consider how they want to position themselves in the marketplace for employees.  They may also want to consider various incentive-based programs for targeted classifications of employees.

- Preserve Tax-Exempt Status.  Non-profit charitable status provides an organization with several benefits and should be protected diligently.  In addition to providing exemption from income tax, this status provides access to tax-exempt debt and offers exemption from property taxes.

## Annual Objectives for Financial Performance.

- Operating Budget.  The annual operating budget should incorporate the organization's financial operating philosophy.  In determining the annual budget, the board must understand the market served, the rate structure and third-party reimbursement play an integral role.

- Capital Budget.  In addition to an operating budget, there should also be an annual capital budget.  Management should justify and prioritize capital needs.  The board should play a role in determining the amount to be budgeted and the source of funds to finance budgeted additions.

- Executive Compensation.  The board is responsible for determining a reasonable level of CEO compensation.  In determining appropriate compensation, consideration should be given to industry comparisons and local conditions.  The compensation should be determined based on a performance evaluation which is based on results.  Executive compensation may include benefits outside the organization's usual benefit structure.  Note that when the hospital files the annual Form 990 with the IRS there is a question that asks whether the process used to determine the compensation of an organization's top management official and other officers and key employees included a review and approval by independent persons, comparability data, and contemporaneous substantiation of the deliberation and process.

## Other Financial Decisions

- Fringe Benefits.  The board provides direction as to the nature of fringe benefits to be offered by the organization.  These benefits include:  pension plans, tax-sheltered annuities, health insurance, live and disability insurance, vacation, holiday and sick leave, cafeteria plans, etc.  Many of these benefits may require input from the board.

- Insurance.  The organization needs to evaluate its exposure to numerous risks.  Coverage for most risks can be provided through insurance policies.  In evaluating risks and insurance policies, consideration should be given to deductible levels and self-insurance.  The board should specifically be interested in directors' and officers' liability insurance.

- Integrate the Financial Philosophy.  Determining financial philosophy is an ongoing process which involves evaluating service to the community, providing for organizational goals and consideration for physician relationships.

## The Board and Government

- Board Liability.  Non-profit board members can be cited for either non-management or mismanagement in a variety of areas stemming from lawsuits brought by employees, government entities, donors, beneficiaries, member of the public or other unrelated parties.  Examples would include:

| Source | Allegation |
|---|---|
| Employees | • Wrongful termination<br>• Breach of employment contract<br>• Violations of civil rights |
| Federal/State/Local Governments | • Violations of civil rights<br>• Conflict of interest<br>• Wage/tax/social security reporting violations<br>• Waste of assets |
| Donors/Beneficiaries/Unrelated Parties/Members of Public | • Breach of duty:  establishment of short/long term goals, meeting short/long term goals, supervision, adequacy of funding mechanisms<br>• Fiscal management:  financial representations/reporting, expenditures, investments<br>• Conflicts of interest<br>• Merger activities with other organizations<br>• Libel/slander/defamation<br>• Federal/state anti-trust violations |

These and any other mismanagement allegations can be brought personally against directors and can jeopardize the director's personal assets.  While the allegations brought against non-profit organization directors are often unfounded and without merit, the cost to defend oneself in such suits is often substantial and can be borne by the director.

- Preserving Exempt Status.  IRS auditors have been given new, detailed guidelines to use when they audit non-profit hospitals to determine whether those facilities should retain their tax-exempt status.  These guidelines include evaluating:  community benefits, unreasonable compensation and private inurement, financial analysis of affiliated entities, joint ventures and independent contractors.  The new guidelines provide specific examples of practices or organization structures that the IRS views as violations or suspect practice.

- Fraud and Abuse.  Fraud and abuse regulations are administered by the Health Care Financing Administration of the Department of Health and Human Services.  The definition of fraud and abuse is not precise.  Fraud and abuse regulations are intended to prevent improper transactions involving the Medicare program.  Among other penalties, fraud and abuse can result in the loss of a hospital's ability to provide service to Medicare beneficiaries.

- Compliance Plans.  While there is no legal requirement to have a corporate compliance program; there is an increasing focus on enforcement actions concerning health care providers.  Efforts to detect and prosecute violation of the many statutes concerning provision of healthcare are likely to receive increased focus in the future.  It is recommended that hospitals develop their own hospital-wide compliance plan.  Hospitals should also be expected to take steps to effectively communicate standards and procedures and all training and attendance should be documented.  Monitoring techniques may include employee interviews, review of billing and coding procedures, review of contracts and related documents, review of marketing materials and promotional literature and similar documents.  Resources to achieve such monitoring may include legal counsel and other outside parties such as MedLearn.

- IRS Form 990.  Although no required to do so by the Internal Revenue Code, some organizations provide copies of the IRS Form 990 to its governing body and other internal governance or management officials, either prior to or after it is filed with the IRS.  The Form 990 has a question that asks whether the organization provides a copy of Form 990 to its governing body, and requires the organization to explain any process of review by its directors or management.

# Information Needed to Meet Board Responsibilities

**Richard A. Donkle, CPA**
**Rural Wisconsin Health Cooperative**

This approach is the same as that used by John Carver in his book titled, *"Boards that Make a Difference."*

## Types of Information Needed

- Decision Information.  Decision information is the information the board receives to make decisions regarding bond financing, budgets, etc.  This type of information is used solely to make board decisions, it is not judgmental and it looks to the future and is used to value some aspects of the future.

- Monitoring Information.  Monitoring information is used to measure whether previous board directions have been satisfied.  It is judgmental because it measures performance and it is retrospective in that it looks at the past.  Good monitoring information is a systematic survey of performance against criteria.  It is more like a rifle shot than a shotgun blast.  It does not demand "tell us everything," but "tell us this, this and that."

- Incidental Information.  Information that is not used for making decisions or monitoring falls is the incidental information category.  This information has no criteria in which to judge the information received.  Some financial reports are incidental.  There is nothing wrong with incidental information.  It can lead to better policy-making.  If the board extracts from this information insights helpful at a board level, the time was well spent.

## Criteria for Monitoring Information

- Preestablished criteria and good monitoring are essential if the board is to relax about the present and get on with the future.  Preestablished criteria saves board time as well as staff time.  The board can avoid the start-from-scratch approval struggle that exists when criteria are unstated.  Also, criteria are necessary because judgment is not fair without criteria, and the board does a far more credible job of judging staff performance.

## Methods of Monitoring Information

- "If you haven't said how it ought to be, don't ask how it is," describes the principle that forces a board to monitor instead of meander.

- Executive Report.  The CEO makes available a report that directly addresses the policy being monitored.

- External Audit.  The board selects an external resource to measure staff compliance with respect to specific board policy.

- Direct Inspection.  The board assigns one or more board members to check compliance with a specific policy.

## Sample Executive Summary

The one page of executive financial summary on the following page addresses key areas the board should be concerned with from a financial point of view.

1. Key financial statements

   - Balance sheets
   - Operating statements

2. Key financial ratios

   - Liquidity ratios
   - Debt capital ratios
   - Profitability ratios

3. Monitoring criteria for each item presented

4. Investment policy

5. Capital budget

6. Operating budget

7. Key statistics

# WHITEC Participant Hospital Meaningful Use Benchmarking Report

Funded by the Wisconsin Office of Rural Health and WHITEC

Prepared by Louis Wenzlow
Director of Health Information Technology
Rural Wisconsin Health Cooperative
February 14, 2012

# Table of Contents

# 1. Executive Summary

This study has been conducted by the Wisconsin Health Information Technology Extension Center (WHITEC) and the Wisconsin Office of Rural Health (WORH) in order to help WHITEC hospitals (Wisconsin hospitals with fewer than fifty beds participating in the WHITEC program) understand where they are with their meaningful use efforts compared to other WHITEC participants, other Wisconsin hospitals, and other rural hospitals across the country.

The forty-one hospitals characterized in this report make up about 60% of Wisconsin hospitals with fewer than fifty beds and 30% of all Wisconsin hospitals. Fifteen of these hospitals are system owned or affiliated, and twenty-six are stand-alone. The WHITEC hospital group has more standalone hospitals than the Wisconsin small hospital population as a whole: 63% of study participant hospitals are stand-alone, compared to 43% of the total number of Wisconsin hospitals with fewer than fifty beds.

2011 has been a year of hard work for WHITEC participant hospitals: over 70% applied for their 1$^{st}$ year Medicaid incentive, 15% attested to meaningful use, and over 60% plan to attest to meaningful use in 2012. Given the challenges rural hospitals face with EHR adoption and the relative time it takes for hospitals (compared to physician practices) to safely implement EHR systems, we believe that the results in this report indicate that both the HIT Incentive Program and the WHITEC REC Program are working well for the majority of rural hospitals here in Wisconsin.

This being said, small rural hospitals continue to face challenges that are specific to their size, patient populations, and locations. Critical Access Hospitals are having a difficult time getting paid compared to PPS hospitals. Small rural hospitals have limited HIT staff to perform the work of implementing and supporting the EHR systems. Broadband access continues to be an issue for our most rural Wisconsin hospitals and their affiliated clinics. And all of these challenges tend to disproportionately impact those hospitals that are most at risk.

As WHITEC sets its sights on the Stage 2 regulations and on providing assistance with the new set of challenges the Stage 2 objectives will bring, we are also keenly aware that most WHITEC participant hospitals will be continuing to work on the issues associated with planning, implementing and fine-tuning their EHRs to achieve Stage 1. Over the last year, we've developed considerable experience working with early attesting hospitals. We stand ready to help WHITEC participant hospitals at any stage of EHR adoption. Please contact us (at lwenzlow@rwhc.com) to see how we can assist.

Primary report results include the following:

**Medicaid Program Participation**
- 78% of WHITEC participant hospitals applied for a 1$^{st}$ year Medicaid payment in 2011. This is higher than the all Wisconsin hospital percentage of roughly 60%, which is the highest percentage of any state in the country.
- The remaining 22% of WHITEC participant hospitals intend to apply for their 1$^{st}$ year Medicaid payment in 2012 (i.e. all intend to have a contract for a complete EHR by 2012).

**Medicare Program/Meaningful Use Attestation**

- 15% of WHITEC participant hospitals attested to meaningful use in FFY 2011, an additional 51% plan to attest in 2012, 17% plan to attest in 2013, and 15% are unsure of when they will attest.
- Based on unofficial data, the WHITEC participant 2011 attestation rate of 15% is higher than the all Wisconsin hospital percentage (11%) and the national CAH percentage (9%).
- As of November 2011, 277 hospitals had received a Medicare payment and of those 12 were CAHs. This means that while 37% of attesting PPS hospitals had received payment, only 10% of attesting CAHs had received payment. The reason for this disparity is that CAHs have the administrative burden of needing to justify their "EHR-related costs" to their MACs prior to getting payment
- The core meaningful use objectives with the highest 2011 adoption rates were Demographics, Drug Interaction, and Medication and Allergy Lists.
- The core MU objectives with the lowest 2011 adoption rates were CPOE, Quality Measures, and Information Exchange.

**Vendors Utilized**
- All but one WHITEC participant hospital was using a "complete" (as opposed to modular) EHR strategy, and 79% were on a certified platform.
- A large majority of WHITEC participants used one of five "complete" EHR vendors—CPSI, Epic, Healthland, HMS, and Meditech—in roughly equal proportions.

**Financial Considerations**
- WHITEC participants received an estimated average of $348,991 in Year 1 Medicaid incentive payments, compared to an average of $536,521 for all Wisconsin hospitals and an average of $775,473 for the nation's hospitals. This discrepancy can likely be attributed to larger hospitals receiving an additional discharge related amount, as well as to higher elderly population and therefore lower Medicaid utilization in rural areas.
- PPS participants will receive an estimated average of $3,465,228 in Medicare payments over the life of the program; and CAH participants will receive an estimated average of $869,772 in payments, with $350,490 of these payments being "actual" bonus over what would have been received through traditional cost-based reimbursement.

**Participant Satisfaction with WHITEC Services**
- The majority of respondents were extremely satisfied and all were satisfied with the MU services provided by WHITEC. Additionally, all respondents indicated they would recommend WHITEC to a colleague and were likely to utilize WHITEC services in the future.

**Technical Assistance Needs Indentified**
- The highest ranked technical assistance needs identified were (1) QI Objective Assistance, (2) Security Assessments, (3) Information Exchange Assistance, and (4) Attestation Assistance. WHITEC has or is developing services in all of these areas.

# 2. Introduction

The Wisconsin Health Information Technology Extension Center (WHITEC) is the federally funded Regional Extension Center responsible for providing meaningful use-related technical assistance to small hospitals and primary care practices in Wisconsin. The WHITEC Small Hospital Program is a collaboration between the Rural Wisconsin Health Cooperative, the Wisconsin Hospital Association, the Wisconsin Office of Rural Health, and Metastar, Wisconsin's Quality Improvement Organization.

Our program provides meaningful use financial assessments, gap assessments, open door Q&A, and education for no cost to hospitals with fewer than fifty beds, as well as fee-based security assessments, QI assessments, and attestation assistance. This Meaningful Use Benchmarking Report is another WHITEC deliverable, intended to help WHITEC participating hospitals understand where they are compared to the (currently) forty-one other hospitals that have signed up for the WHITEC program.

In addition to comparing participating hospitals against each other, whenever possible we are taking the opportunity to benchmark the WHITEC cohort against other hospital categories: all Wisconsin hospitals, all of the nation's hospitals, and all of the nation's rural hospitals. The goal is to capture a snapshot of a specific point in time, so that a year from now, and two years from now, we can look back and see how we've improved and what we've learned as a group.

One important caveat is that the information we are presenting is in a rapid state of change. As more and more hospitals attest to meaningful use and get paid, CMS is posting monthly updated reports with dramatically different data. Our intention is to identify where we were as of September 30th 2011, the end of the 1st meaningful use hospital federal fiscal year. The Medicare Incentive program allowed for 2011 attestation through November of 2011; and the Wisconsin Medicaid program allowed for 2011 applications through December. So it's only recently that we've seen the first sources of data that begin to represent what happened through the end of Meaningful Use Year 1.

The hospitals characterized in this report include three rural Wisconsin PPS hospitals and thirty-eight rural Wisconsin Critical Access Hospitals (CAHs). These hospitals make up about 60% of Wisconsin hospitals with fewer than fifty beds and 30% of all Wisconsin hospitals. Fifteen of these hospitals are system owned or affiliated, and twenty-six are stand-alone. The WHITEC hospital group has more standalone hospitals than the Wisconsin small hospital population as a whole: 63% of study participant hospitals are stand-alone, compared to 43% of the total number of Wisconsin hospitals with fewer than fifty beds.

The WHITEC participant data was gathered through surveys and onsite visits to perform meaningful use gap assessments and financial assessments. Not every WHITEC participant hospital had each of these assessments performed (some participated in one but not the other). We've noted whenever data from less than the entire pool of forty-one is being used.

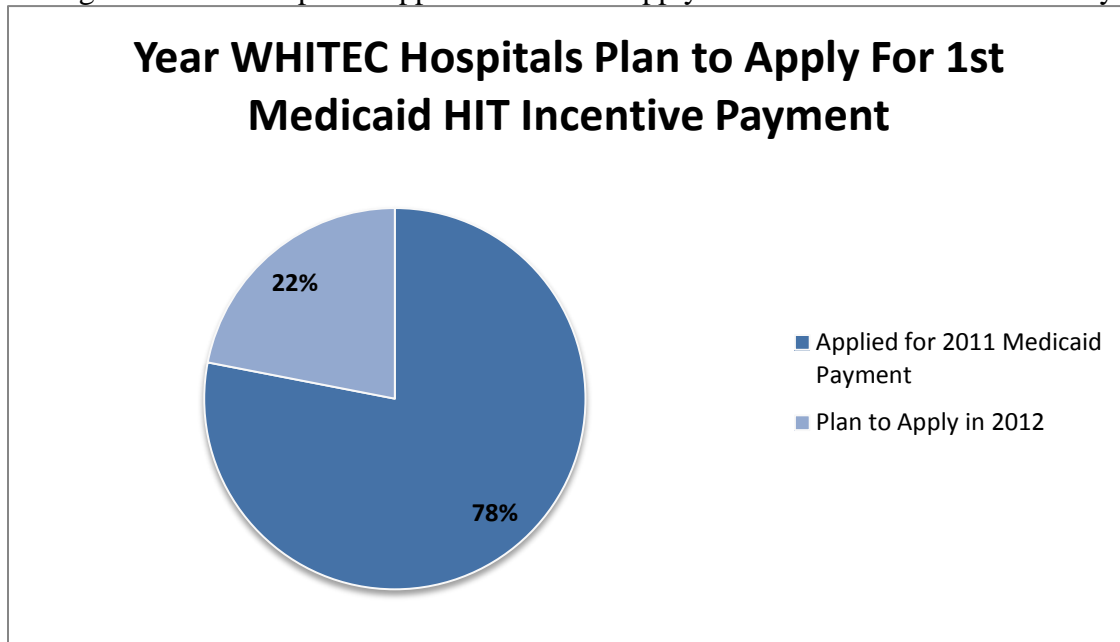The data used to compare the participant pool to national and State averages is primarily from CMS released reports and datasets. CMS has not yet released comprehensive and precisely defined "official" data on 2011 FFY meaningful use attestations, and its unclear when or even whether this will happen. We've moved forward with the best data available and identified those circumstances where the data is subject to change.

# 3. WHITEC Participant Medicaid Application Status

Rural hospital participation in Wisconsin's Medicaid HIT Incentive program has been a major WHITEC focus. WHITEC worked through RWHC and WHA with Wisconsin DHS to inform the establishment of the State's program, and then worked directly with WHITEC participant hospital stakeholders to assist them with qualification, registration, and application issues. WHITEC hospital Medicaid participation results include:

- All WHITEC participant hospitals met the 10% Medicaid utilization eligibility requirement.[1]
- As indicated in Figure 1, 78% (32 of the 41 WHITEC participant hospitals) applied for a 2011 Medicaid incentive payment and the remaining 9 hospitals plan to apply in 2012.
- This means that all forty-one WHITEC participant hospitals have or plan to have contracts for a complete certified EHR or for certified EHR modules that make up a complete EHR by 2012.[2]
- The main reasons that certain hospitals are waiting to apply until 2012 include: (1) there is not yet a signed contract for certified EHR (required to qualify for a Medicaid payment), and (2) Medicare registration problems.
- According to the most recent CMS "YTD Combined Medicare Medicaid Payments by State" report[3], Wisconsin had 75 hospitals that had received their 2011 Medicaid payment for a total of over $39,000,000 in payments. Only 2 states had a larger number of hospitals that received payment: Florida with 91 and Texas with 263. However, Wisconsin has roughly 130 hospitals compared to Florida's 225 and Texas' nearly 500, so **Wisconsin has the highest percentage of hospitals that have received a 2011 Medicaid payment.**

Figure 1: Year Hospitals Applied or Plan to Apply for Their 1st Year Medicaid Payment



**Year WHITEC Hospitals Plan to Apply For 1st Medicaid HIT Incentive Payment**

- ■ Applied for 2011 Medicaid Payment
- ■ Plan to Apply in 2012

22%

78%

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[1] Medicaid program eligibility is calculated by determining the hospitals' best 90 days of ED and inpatient Medicaid utilization, with secondary Medicaid claim encounters included in the numerator

[2] Such contracts are required to meet the Medicaid "adopt/implement/upgrade" standard and qualify for payment

[3] http://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp#TopOfPage

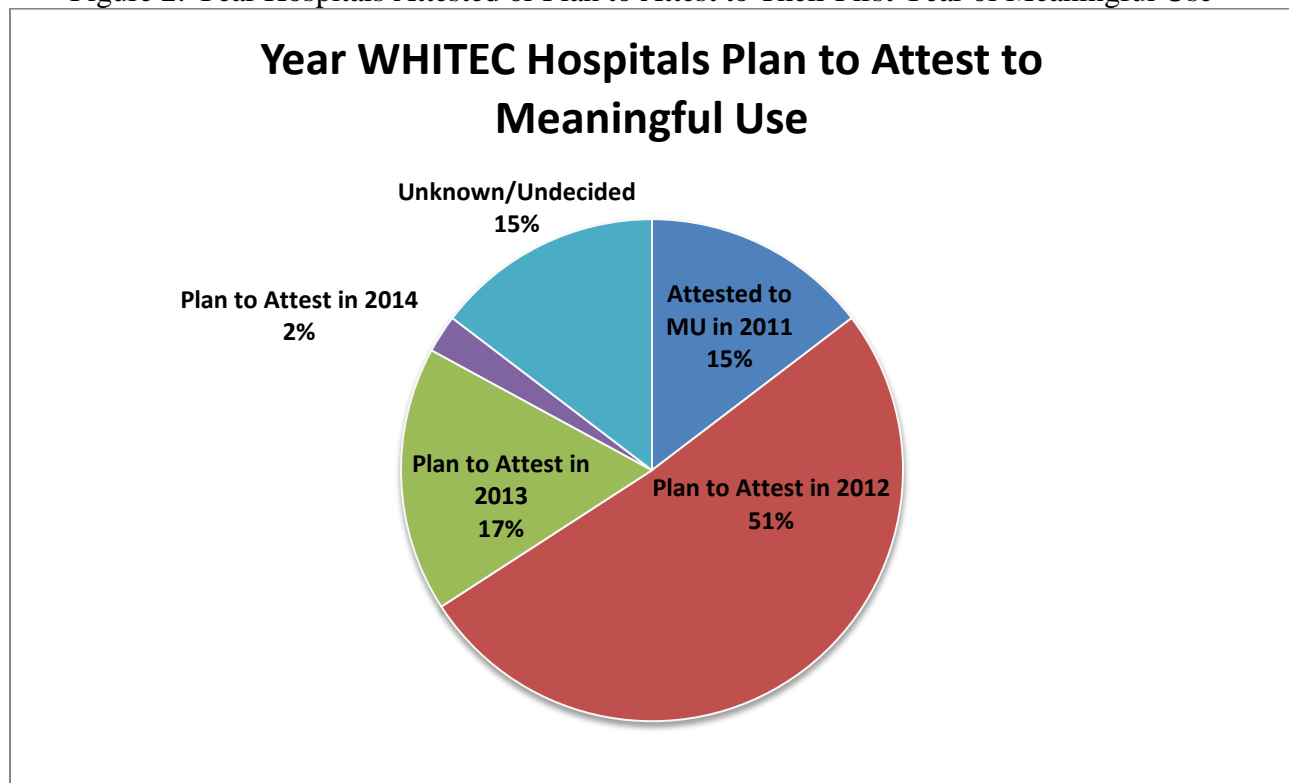# 4. WHITEC Participant Meaningful Use Status

## A. WHITEC Participant EHR Adoption and MU Attestation Rates

Wisconsin rural hospitals have been consistently ahead of the national curve when it comes to EHR adoption. According to the 2010 AHA Hospital Survey, 25% of Wisconsin rural hospitals had implemented a "basic" EHR, compared to 14% of national rural hospitals. According to RWHC's 2009 "Density of HIT Adoption in Wisconsin Rural Hospitals" report[4], nearly 50% of respondents had implemented an inpatient clinical documentation system and over 80% of respondents had implemented pharmacy, lab, radiology, and order entry systems. Additionally, over 70% of survey respondents were utilizing integrated hospital information system vendors that have gone on to become certified "complete EHR" vendors.

Due to the above, a significant majority of WHITEC participant hospitals joined the WHITEC program already well positioned to build off of their previous work and achieve meaningful use in the early years of the incentive program. WHITEC has been assisting by providing meaningful use education, financial assessments, meaningful use gap assessments, and other services.

As indicated in Figure 2, 15% of WHITEC participant hospitals attested to meaningful use in 2011 and an additional 51% plan to attest in 2012. This means that 66% of current WHITEC participant hospitals plan to be meaningful use attesters in the first two years of the program.

Figure 2: Year Hospitals Attested or Plan to Attest to Their First Year of Meaningful Use



Year WHITEC Hospitals Plan to Attest to Meaningful Use

- Unknown/Undecided 15%
- Plan to Attest in 2014 2%
- Plan to Attest in 2013 17%
- Attested to MU in 2011 15%
- Plan to Attest in 2012 51%

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[4] http://www.rwhc.com/Resources/CartoonsPolicyPapers/PolicyOpinionPapers.aspx

**B. WHITEC Participant Attestation Rates Compared to Wisconsin and National Averages**

How does this data compare to all Wisconsin hospitals and to rural hospitals nationally? The best data we have for comparison is the CMS/ONC "Electronic Health Record Products Used for Attestation" raw dataset, which has allowed us to calculate how many hospitals and separately CAHs had attested to meaningful use through (we think) November, 2011.[5]

Based on this dataset, 11% of all Wisconsin hospitals, 10% of Wisconsin CAHs, 9% of the nation's CAHs, and 16% of all of the nation's hospitals had attested to meaningful use at the time the data was cut. The WHITEC participant attestation rate of 15% exceeds the Wisconsin hospital and national CAH averages and nearly equals the national all hospital attestation average.

**C. Wisconsin Hospital EHR Adoption versus MU Attestation Anomaly**

While it's tempting to equate meaningful use attestation rates with EHR adoption rates, there are reasons to believe that Wisconsin hospitals are farther along with EHR adoption than their attestation rates indicate. Based on the above-mentioned raw dataset, Wisconsin's overall average of 11% of 2011 hospital meaningful use attesters is significantly below the national overall average of 16%. However, as identified in Figure 3, 2010 AHA data shows that 30% of Wisconsin hospitals indicated they had adopted a basic EHR compared to 19% of the nation's hospitals.

Figure 3: AHA Hospital Survey Adoption of EHRs by All and Wisconsin Hospitals
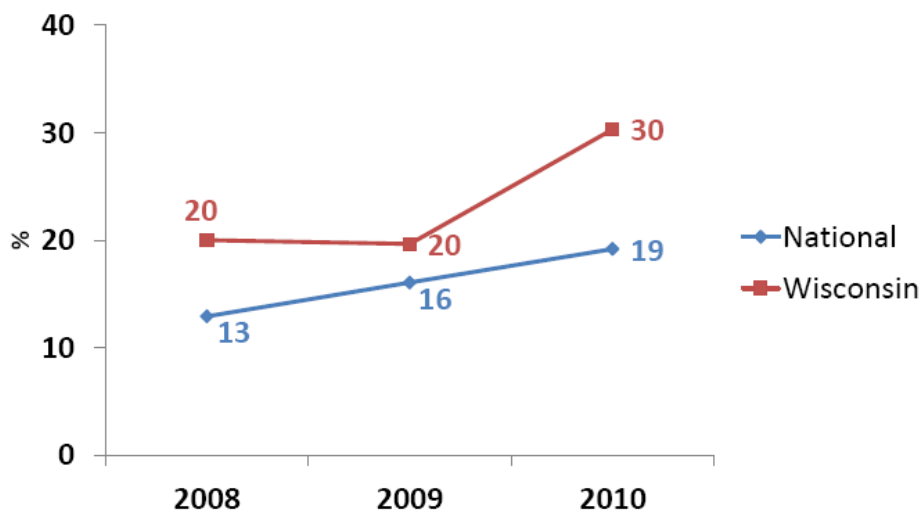


Data Source: AHA Hospital Survey

Why the discrepancy between Wisconsin hospital EHR adoption and 2011 attestation? We know that Wisconsin hospitals did not halt their EHR adoption efforts in 2011, and we don't necessarily believe that the data is inaccurate. It is our opinion (supported anecdotally by discussions with Wisconsin hospital representatives) that the primary reason for the discrepancy has to do with many Wisconsin hospitals

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[5] http://www.worh.org/hit/2012/01/meaningful-use-attestations-in-2011-cmsonc-raw-dataset-tells-hospital-story/

deciding not to attest until 2012 for primarily strategic reasons (including Stage 2 timing issues[6]). Judging from the large number of WHITEC participant hospitals that plan to attest in 2012, we may soon see Wisconsin hospital attestation rates spike above the national average. Next year's report will return to this issue.

## D. CAH versus PPS Hospital MU Attestations Compared to Payments Received

A recent "CMS Monthly Payment Registration Report[7]" indicated that through November 2011, 277 hospitals had received a Medicare payment and of those 12 were CAHs. This means that while 37% of attesting PPS hospitals had received payment, only 10% of attesting CAHs had received payment. The reason for this disparity is that CAHs have the administrative burden of needing to justify their "EHR-related costs" to their MACs prior to getting payment, whereas PPS hospitals get an incentive payment based on a fixed formula. Therefore, CMS payment data—at least currently—is not especially helpful in estimating CAH EHR adoption rates.

## E. WHITEC Participant Meaningful Use Core and Menu Objectives Achieved and Targeted

WHITEC has performed meaningful use gap assessments for over 30 of the WHITEC participant hospitals. As part of these assessments, hospitals identified their target dates for meeting each of the 24 Stage 1 meaningful use objectives. The results for 2011 and 2012 are represented in figures 4 and 5. Hospitals that met the objective in 2011 are included in the 2012 cohort, since the expectation is that they will continue to meet the objective in 2012.

Figure 4: % of Hospitals Targeting Core Objective Completion in 2011 and 2012



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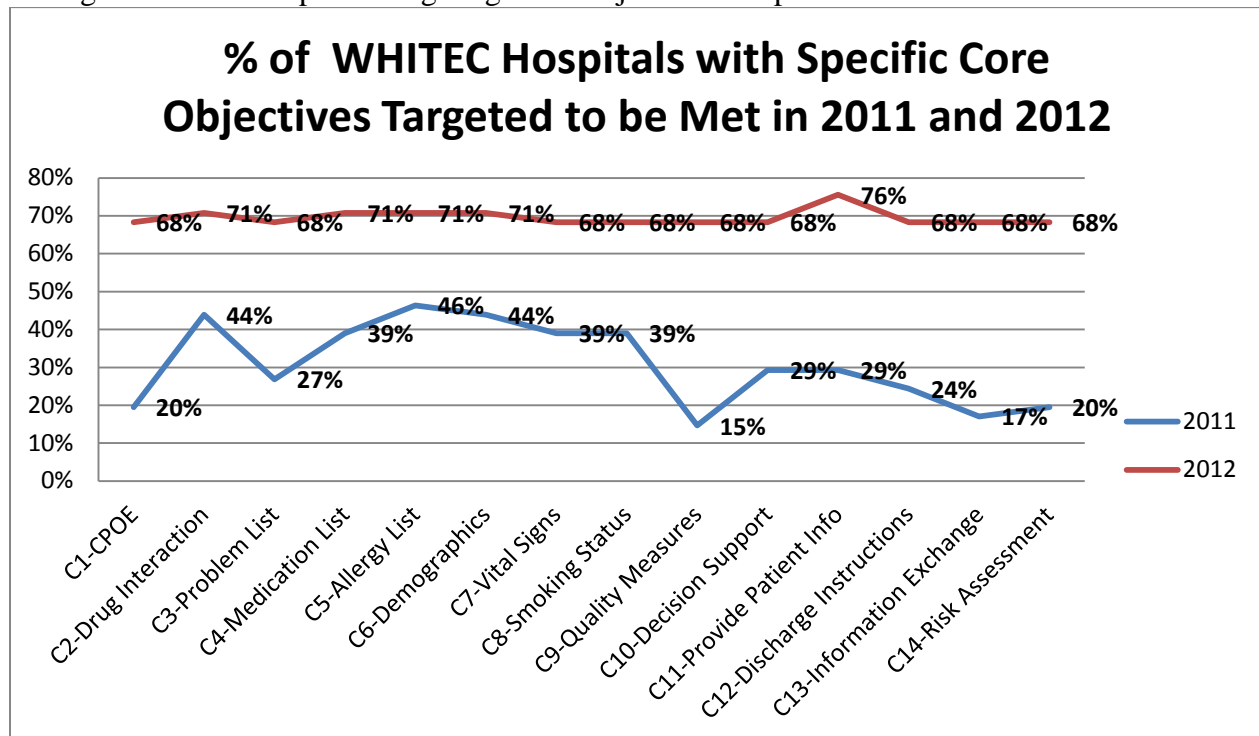
[6] http://www.worh.org/hit/2011/11/hhs-secretary-intends-to-extend-stage-2-mu-deadline/
[7] http://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp#TopOfPage

Figure 5: % of Hospitals Targeting Menu Objective Completion in 2011 and 2012



**% of WHITEC Hospitals with Specific Menu Objectives Targeted to be Met in 2011 and 2012**
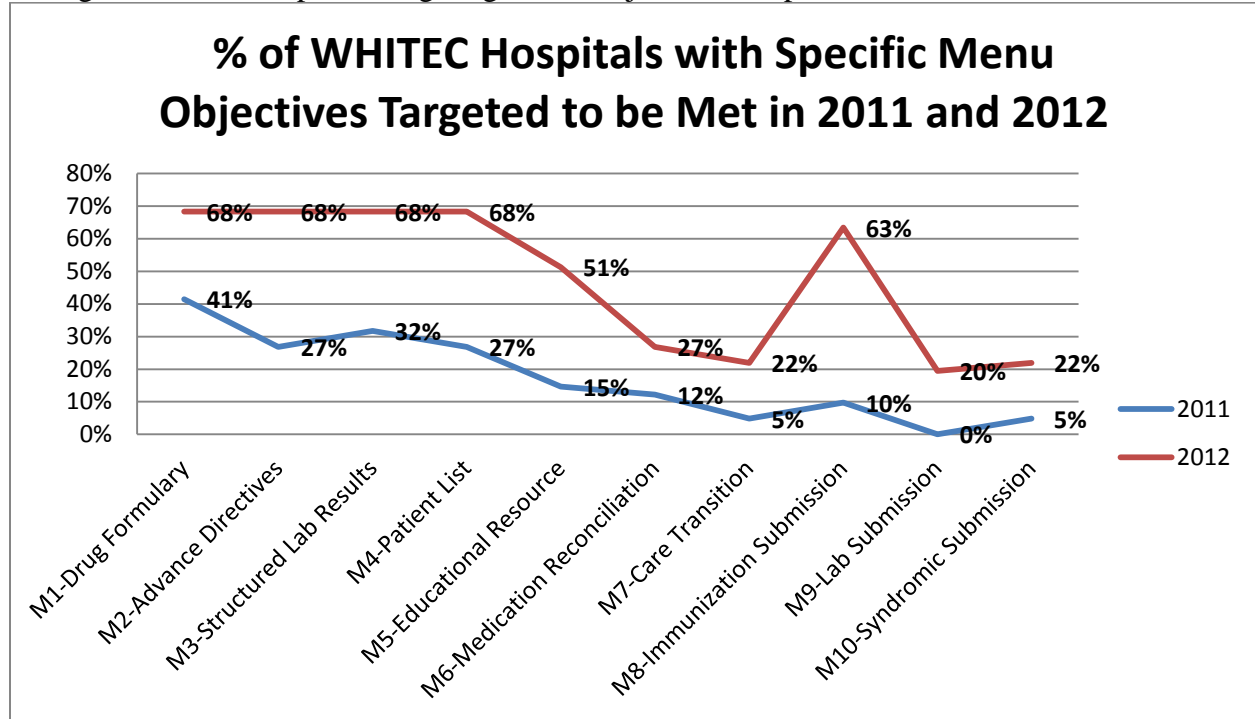
Commentary on MU objective results:

- As expected, the objectives with the highest 2011 implementation rates correlate to systems that have historically high adoption rates: Drug Interaction Checks, Medication Lists, Allergy Lists, and Drug Formulary utilization correlate to inpatient Pharmacy systems; Demographic information capture correlates to Registration systems; and Vital Sign and Smoking Status capture correlate to Nurse Documentation systems. All of these systems had a relatively high penetration in Wisconsin rural hospitals prior to the HITECH Act.

- The core objectives with the lowest 2011 implementations rates were CPOE, Quality Measure data capture, and Information Exchange. This was also to be expected, since CPOE is a capstone application with historically low adoption rates, and the specific Quality Measure and Information Exchange objectives generally involved the implementation of new functionality (hot off the vendors' presses) and/or new challenging workflows.

- The menu objectives with the lowest 2011 implementation rates were the provision of a Transition of Care Summary, electronic Medication Reconciliation, and the Public Health submission objectives. The Public Health submission implementation rates are low due primarily to limited or no State capability to accept submissions. The Transition of Care and Medication Reconciliation implementation rates are low due to the fact that they are generally considered to be the more challenging objectives in a menu set in which only 5 out of 10 objectives are required to be met.

- Looking to 2012 (consistent with the meaningful use attestation targets identified in Section 4.A.), over 65% of hospitals plan to achieve all of the core and 5 of the menu objectives, with immunization submission being the generally preferred public health submission option.

# 5. WHITEC Participant Certified EHR Vendor Utilization

## A. EHR Platform Certification Status and Type

As indicated in Figure 6, 97% of WHITEC MU Gap Assessment participants are utilizing a "Complete" EHR strategy rather than a modular or self-certification approach. And as indicated in Figure 7, 79% were on the certified version of their vendor's platform. Most of the remaining 21% were either in their vendor's queue for moving to a certified version or else had contracted for a new certified installation.

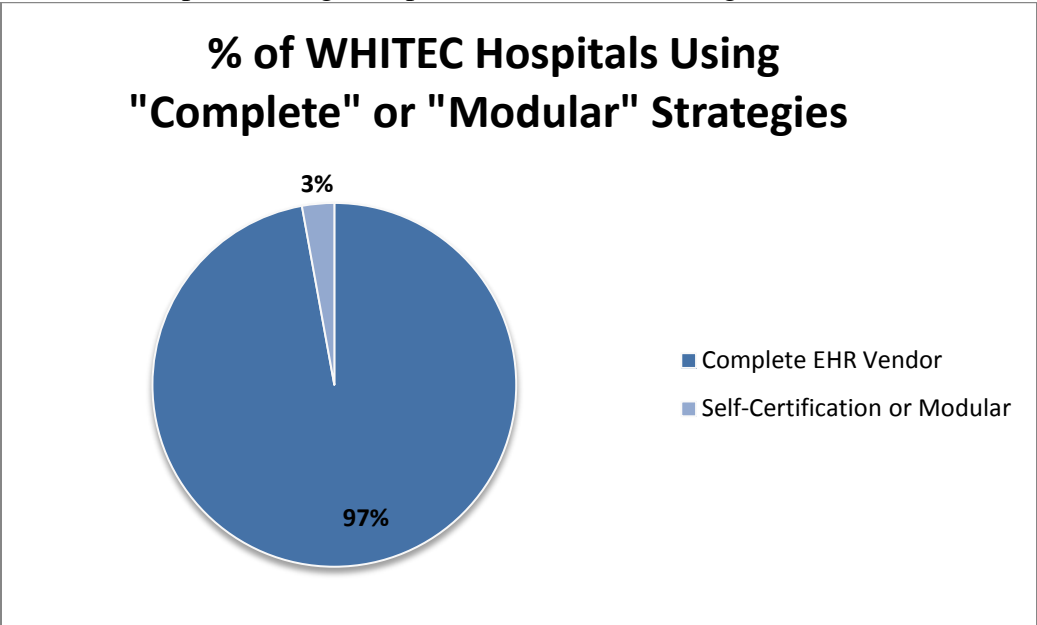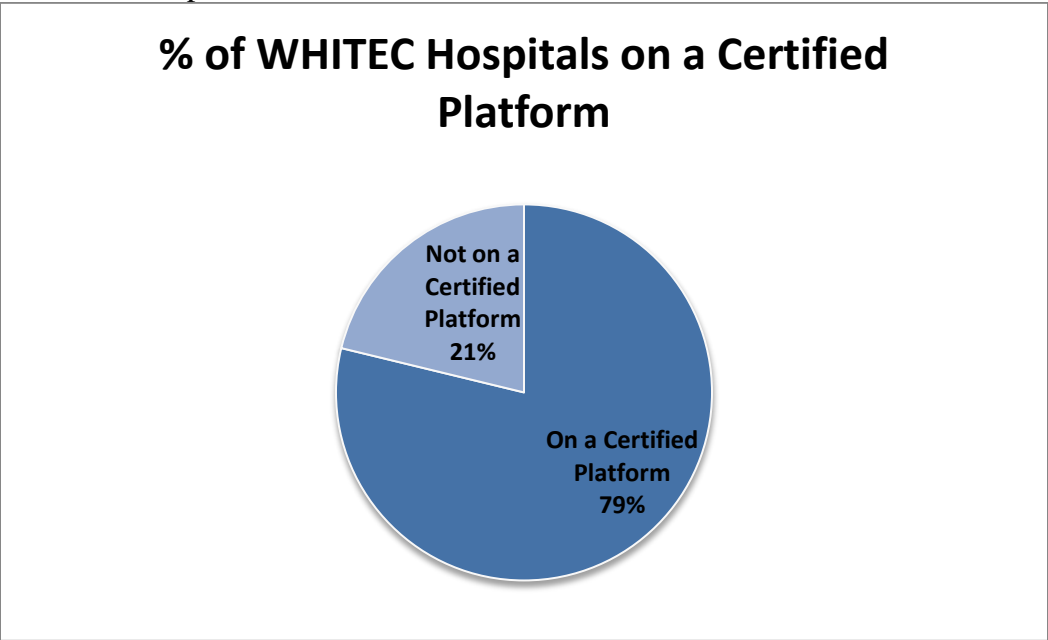Figure 6: % of Hospitals Using Complete and Modular Strategies



Figure 7: % of Hospitals on a Certified EHR Platform

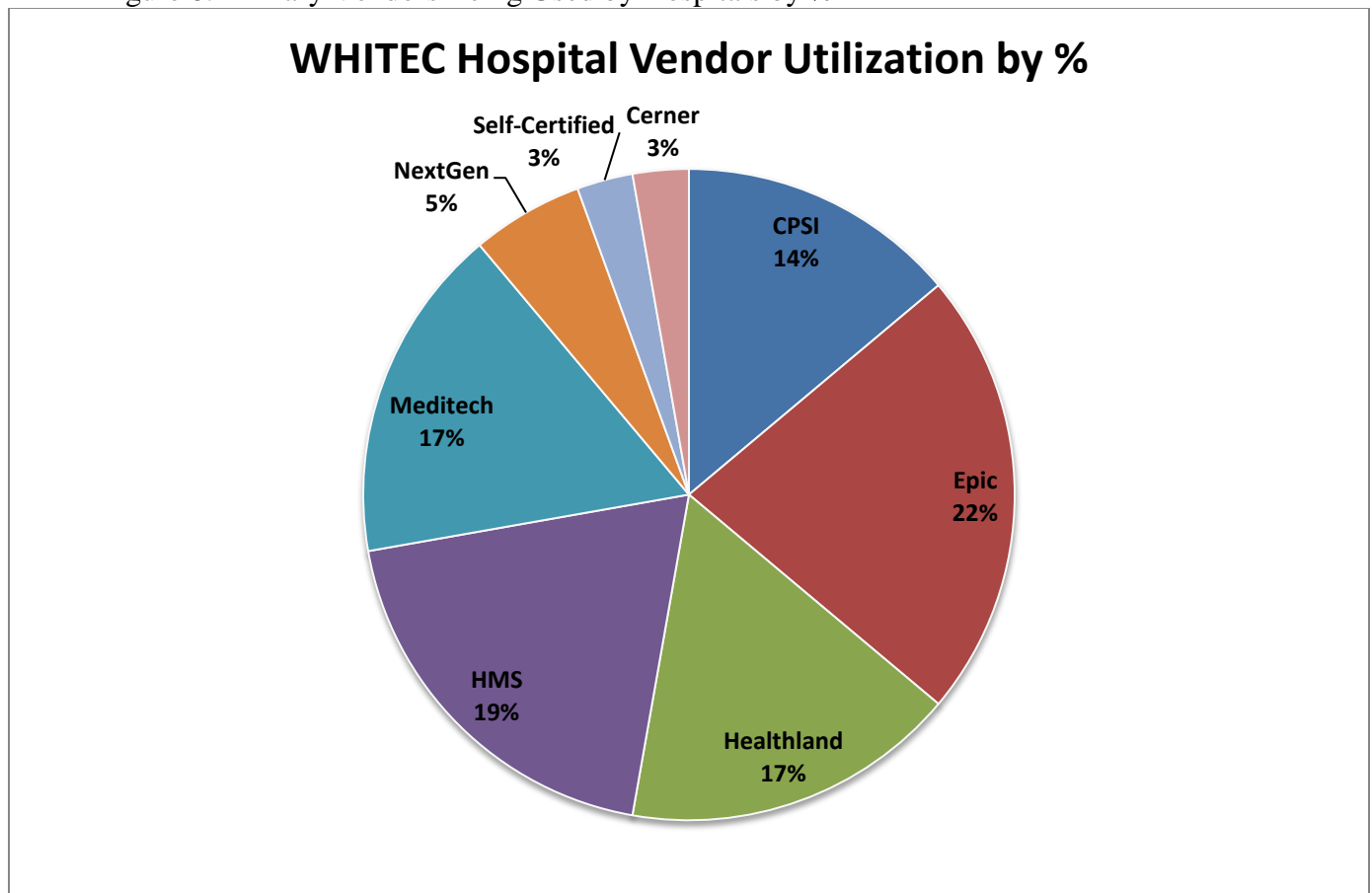**B. Vendors in Use by WHITEC Participant Hospitals**

As indicated in Figure 8, the vast majority of WHITEC participants are utilizing one of five "complete" EHR vendors in roughly equal proportions.

Since Epic does not sell directly to small community hospitals, WHITEC participant hospitals using Epic are doing so through a large hospital or system, usually as part of an affiliation relationship. WHITEC participant hospitals using Cerner, CPSI, Healthland, HMS, Meditech, and NextGen are generally independent CAHs and small PPS hospitals that are implementing independently or with the help of a network organization.

Two of the six WHITEC participant hospitals that attested to meaningful use in 2011 utilize Epic, another two utilize HMS, one utilizes CPSI, and one utilizes Healthland.

While we've seen a small number of hospitals changing to new vendors for a variety of reasons, WHITEC participant hospitals have generally stayed with the vendors they were using prior to the establishment of the ONC-ATCB certification program.

Figure 8: Primary Vendors Being Used by Hospitals by %



WHITEC Hospital Vendor Utilization by %

- Self-Certified 3%
- Cerner 3%
- NextGen 5%
- CPSI 14%
- Epic 22%
- Healthland 17%
- HMS 19%
- Meditech 17%

# 6. WHITEC Participant EHR-Related Financial Considerations

The purpose of this section is to provide WHITEC participants with a high-level environmental scan of the HIT Incentive Program's financial impact on rural Wisconsin hospitals. While we don't yet have any official data on Medicare payments (due to issues identified in 4.D.), many WHITEC participants have received Year 1 Medicaid payments, and we've worked with hospitals to estimate Medicare payments pending MAC review and approval. The below information is based on financial survey responses from 35 WHITEC rural hospital participants.

## A. Estimated Medicaid Incentives for WHITEC, Wisconsin, and the Nation's Hospitals

Wisconsin's Medicaid Incentive Program is structured to pay out the total Medicaid amount over three years, with 50% paid in Year 1, 40% paid in Year 2, and 10% paid in Year 3 (this is the most aggressive state payout structure allowed by rule).

WHITEC Financial Assessment participants received or will receive an estimated **average of $348,991 in Year 1 Medicaid incentive payments**, and will receive an estimated average of $707,872 in total incentive payments over the 3 year period.

Based on the most recent CMS "YTD Combined Medicare Medicaid Payments by State" report[8], 74 **Wisconsin hospitals** have received a total of $39,702,611 for an **average of $536,521** per hospital, and 1015 of the **nation's hospitals** have received a total of $787,105,900 for an **average of $775,473** per hospital in Year 1 Medicaid incentive payments.

The Wisconsin hospital Year 1 payout average is significantly lower than the nation's average, and Wisconsin's rural hospital payout average is significantly lower than the Wisconsin hospital average. This discrepancy can likely be attributed to larger hospitals receiving an additional discharge related amount, as well as to higher elderly population and therefore lower Medicaid utilization in rural areas.

## B. Estimated Medicare Incentives for PPS Hospitals

As indicated in the introduction, WHITEC participants include both PPS hospitals and Critical Access Hospitals. Unlike Medicaid, Medicare treats PPS and Critical Access Hospital's differently.

PPS hospitals that achieve the MU objectives by 2013 will receive 4 years of bonus payments based on a fixed formula [($2 Million Base Payment + Discharge Related Payment) x Medicare Share)]. PPS Hospitals that achieve meaningful use starting in 2011-2013 and maintain meaningful use status for 4 years will receive 4 years of incentive payments: 100% of the payment formula their first payment year, 75% the second year, 50% the third year, and 25% the fourth year.

WHITEC Financial Assessment **PPS hospital participants will on average receive an estimated $3,465,228 in Medicare incentive payments** over the 4 year period, assuming MU achievement.

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[8] http://www.cms.gov/EHRIncentivePrograms/56_DataAndReports.asp#TopOfPage

## C. Estimated "Certified EHR Expenses" for CAHs

All eligible CAHs that achieve the meaningful use objectives between 2011 and 2015 will receive up to 4 years of immediately depreciable payments corresponding to their Medicare Share (with 20% add-on) multiplied by the CAH's undepreciated eligible certified EHR expenses.

WHITEC Financial Assessment **CAH participants have estimated that they will have an average of $1,019,285 in eligible certified EHR expenses** (the lowest and highest estimated amounts have been removed before averaging). It should be noted that what constitutes a certified EHR expense has not yet been clearly defined, and actual certified EHR expense amounts depend on MAC approval and future CMS rulings. It is therefore likely that the CAH eligible expense and incentive amounts will turn out to be lower than what is estimated in this report.

Certified EHR expense amounts were estimated at anywhere between $400,000 and over $4,000,000, and depended on several factors, including (1) whether the hospital was incrementally adding modules to achieve MU or purchasing a hospital EHR from scratch, (2) the size of the hospital, and (3) whether a low or high cost vendor was being implemented.

## D. Estimated "Total" Medicare Payments for CAHs

Based on these estimated certified EHR expenses, WHITEC Financial Assessment **CAH participants will on average receive an estimated $869,772 in "total" Medicare incentive payments**.

It should be noted that while CMS will consider this to be the incentive payment amount, only a portion of this average is an actual bonus over what the CAH would have received through traditional cost-based reimbursement. See 6.E. for our estimate of the average actual bonus.

## E. Estimated "Actual" Medicare Incentives for CAHs

In order to calculate the actual Medicare bonus amount, we estimated traditional Medicare share by excluding Medicare Advantage days and the Charity Care Adjustment from the HITECH Medicare Share calculation, as well as by excluding the 20% CAH add-on.

Based on their estimated certified EHR expenses, and by subtracting an estimate of what they would have received through traditional Medicare cost-based reimbursement from their HITECH "total" amount, WHITEC Financial Assessment **CAH  participants will on average receive an estimated $350,490 in "actual" Medicare incentive payments.**

## F. Sustainability Considerations

Based on these estimates, WHITEC participant PPS hospitals will on average receive $4,173,100 in Incentive Program (both Medicare and Medicaid) payments over the life of the program, and WHITEC participant CAH hospitals will on average receive $1,058,362 in "actual" Incentive Program payments over the life of the program.

What does this mean in the context of EHR sustainability? For CAHs, it is important to remember that only a circumscribed category of costs are partially reimbursed through the Medicare incentive. Various capital and all operating costs are not reimbursed at the bonus amount. A CAH, for example, that needs to hire two additional FTEs to support their new EHR environment could have an additional $500,000-$800,000 in FTE costs alone over a 5 year period, only a portion of which (on average 40%) would be reimbursed through traditional cost-based reimbursement.

We have not collected the data we need to perform a sustainability analysis, but will attempt to pursue this issue in future benchmarking reports.

# 7. Technical Assistance Needs Identified

WHITEC MU Gap Assessment participants were surveyed to identify their most pressing technical assistance needs. Figure 9 represents the aggregate weight respondents placed on various TA services.

Figure 9: Technical Assistance Needs Identified
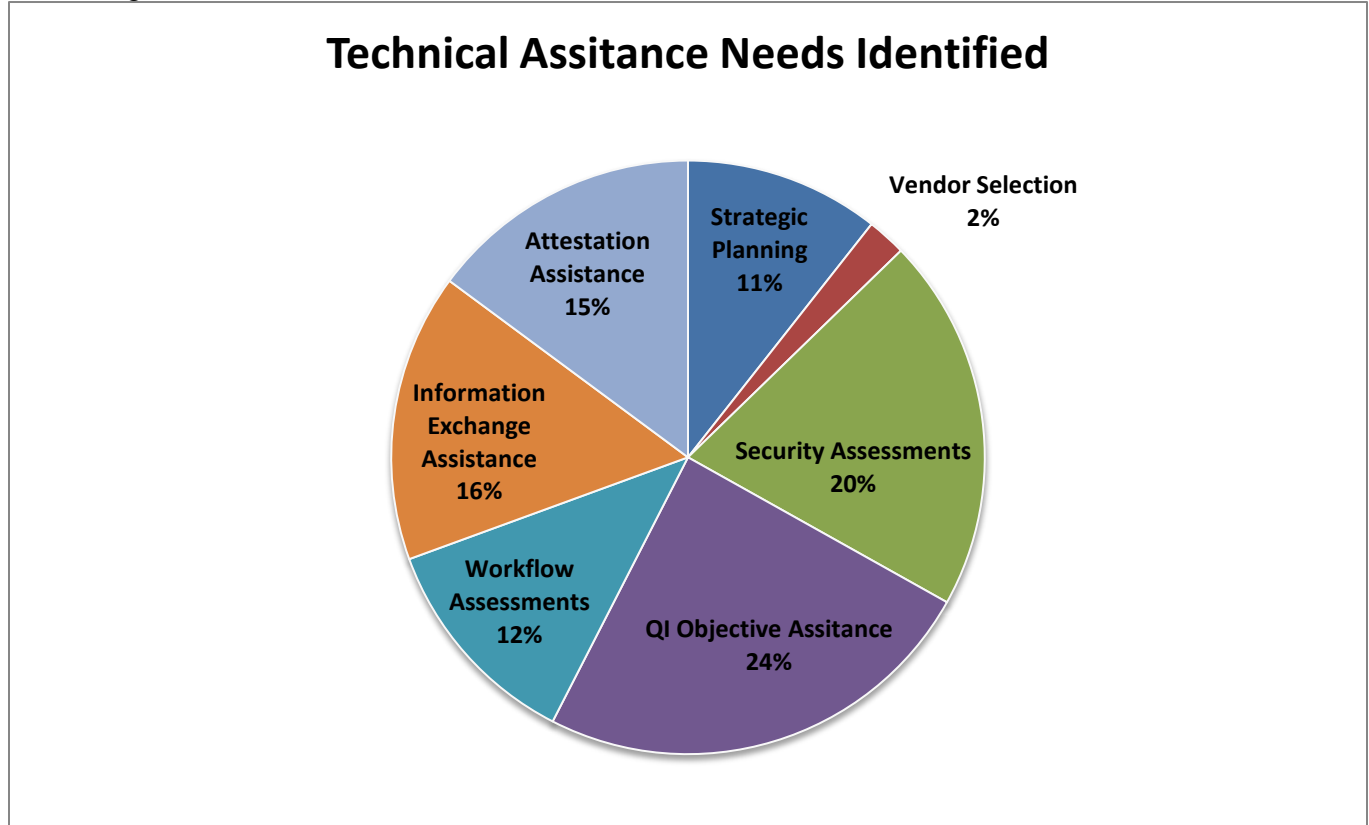


In response to these results, WHITEC has begun providing a number of fee-based services:
- QI Objective Assessments: WHITEC staff helps identify where the hospital QI measure data elements reside within the hospital's EHR, and provides recommendations for meeting the QI objective and enhancing quality.
- Security Risk Assessments: WHITEC staff follows NIST guidelines to perform a risk assessment that identifies potential risks and remediation steps, and facilitates the meeting of the Security objective.

- Attestation Assistance Service: WHITEC staff assists the hospital in gathering MU threshold numerators and denominators, and compiles a comprehensive attestation packet with all relevant FAQs, final rule language, vendor reports, HIE documentation, etc.

In addition to providing the above services, WHITEC staff works closely with Wisconsin's statewide information exchange organization (WISHIN) to ensure that Wisconsin rural hospitals have the TA they need to participate in WISHIN information exchange services and pilot projects.

Looking forward, WHITEC will be devoting significant resources to educating providers on the Stage 2 Notice of Proposed Rule-Making (NPRM) and eventual final rule in order to help hospitals prepare for Stage 2 MU requirements.

# 8. WHITEC Participant Satisfaction Survey Results

In September 2011, WHITEC participants were surveyed on their satisfaction with the WHITEC meaningful use gap assessment and financial assessment services. The majority of respondents were extremely satisfied and all were satisfied with the services provided. Additionally, all respondents indicated they would recommend WHITEC to a colleague and were likely to utilize WHITEC services in the future.

# 9. Conclusion

2011 has been a year of hard work for WHITEC participant hospitals: over 70% applied for their 1st year Medicaid incentive, 15% attested to meaningful use, and over 60% plan to attest to meaningful use in 2012. Given the challenges rural hospitals face with EHR adoption and the relative time it takes for hospitals (compared to physician practices) to safely implement EHR systems, we believe that the results in this report indicate that both the HIT Incentive Program and the WHITEC REC Program are working well for the majority of rural hospitals here in Wisconsin.

This being said, small rural hospitals continue to face challenges that are specific to their size, patient populations, and locations. Critical Access Hospitals are having a difficult time getting paid compared to PPS hospitals. Small rural hospitals have limited HIT staff to perform the work of implementing and supporting the EHR systems. Broadband access continues to be an issue for our most rural Wisconsin hospitals and their affiliated clinics. And all of these challenges tend to disproportionately impact those hospitals that are most at risk.

As WHITEC sets its sights on the Stage 2 regulations and on providing assistance with the new set of challenges the Stage 2 objectives will bring, we are also keenly aware that most WHITEC participant hospitals will be continuing to work on the issues associated with planning, implementing and fine-tuning their EHRs to achieve Stage 1. Over the last year, we've developed considerable experience working with early attesting hospitals. We stand ready to help WHITEC participant hospitals at any stage of EHR adoption. Please contact us (at lwenzlow@rwhc.com) to see how we can assist.

# EHR Incentive Program for Medicare Hospitals

The American Recovery and Reinvestment Act (Recovery Act) of 2009 provides for Medicare incentive payments beginning in federal fiscal year (FY) 2011 for eligible acute care inpatient hospitals that are meaningful users of certified electronic health record (EHR) technology. Eligible acute care inpatient hospitals are defined as "subsection (d) hospitals" in section 1886(d)(1)(B) of the Act—which are hospitals that are paid under the hospital inpatient prospective payment system (IPPS) and are located in one of the 50 states or the District of Columbia. Section 1853(m)(2) of the Act also specifies that qualifying Medicare Advantage (MA) organizations will be eligible for incentive payments by way of their MA-affiliated eligible hospitals. An MA-affiliated eligible hospital is a "subsection (d)" hospital that operates under common corporate governance with a qualifying MA organization and serves primarily individuals enrolled under MA plans offered by such organizations.

Medicare hospitals and MA-affiliated eligible hospitals that adopt a certified EHR system and are meaningful users can begin receiving incentive payments in any year from FY 2011 to FY 2015.

While the law defines a payment year in terms of a federal fiscal year beginning with FY 2011, a hospital does not have to begin receiving incentive payments in FY 2011. Hospitals can begin receiving payments in any year from FY 2011 to FY 2015; however, the incentive payment will decrease for hospitals that start receiving payments in 2014 and later. Hospitals that are not meaningful users of certified EHR technology beginning in FY 2015 will be subject to payment adjustments.

## Medicare Incentive Payment Calculation

Regardless of the payment year, the Medicare incentive payment is the **product** of three factors:

1. **An Initial Amount**
2. **The Medicare Share**
3. **A Transition Factor applicable to the payment year**

This payment methodology will be utilized to calculate Medicare hospital-based EHR incentive payments for eligible hospitals participating under both the Medicare fee for service and MA incentive programs.

## Initial Amount

**Initial Amount = a base amount of $2,000,000 + a discharge-related amount**

The Initial Amount is the sum of a base amount and a discharge-related amount. The base amount is $2,000,000, and the discharge-related amount provides an additional $200 for each acute care hospital discharge during a payment year, beginning with a hospital's 1,150th discharge of the year and ending with a hospital's 23,000th discharge of the year. No additional payment is made for discharges prior to the 1,150th discharge or for those discharges after the 23,000th discharge.

Data on acute care hospital discharges from the hospital's most recently filed 12-month cost report at the time of the calculation will be used as the basis for making preliminary incentive payments. Final payments will be determined at the time of settling the first 12-month cost report for the hospital FY that begins after the beginning of the payment year and settled on the basis of the hospital discharge data from that cost reporting period. For example, for an eligible hospital with a cost reporting period running from July 1, 2010 through June 30, 2011, CMS would employ the relevant data from the hospital's most recently filed 12-month cost report at the time of the calculation (most likely the June 30, 2010 cost report) to determine the preliminary incentive payment for the hospital during FY 2011. However, the final incentive payment would probably be based on hospital discharge data from the cost report beginning July 1, 2011 (fiscal year ending June 30, 2012) and determined at the time of settlement for that cost reporting period. If that cost report is not filed for a 12-month period, the next full 12-month cost report would be employed.

For purposes of determining the Initial Amount, three classes of hospitals are distinguished on the basis of the number of discharges as shown in Table 1.

**Table 1: Initial Amount Calculation**

| Type of Hospital | Hospitals with 1,149 or fewer discharges during the payment year | Hospitals with at least 1,150 but no more than 23,000 discharges during the payment year | Hospitals with 23,001 or more discharges during the payment year |
|---|---|---|---|
| Base Amount | $2,000,000 | $2,000,000 | $2,000,000 |
| Discharge-Related Amount | $0 | $200 x (n – 1,149)<br><br>**(n is the number of discharges during the payment year)** | $200 x (23,001 – 1,149) |
| Total Initial Amount | $2,000,000 | Between $2M and $6,370,400 depending on the number of discharges | Limited by law to $6,370,400 |

## Medicare Share

The formula for the Medicare Share calculation is as follows:

$$\frac{\text{\# of IP Part A Bed Days} + \text{\# of IP Part C Days}}{\text{Total IP Bed Days} \times \left[ \dfrac{\text{Total Charges - Charges Attributable to Charity Care}}{\text{Total Charges}} \right]}$$

IP=inpatient

The second step in determining the hospital payment for a meaningful user of certified EHR technology is to calculate the Medicare Share. As in calculating the Initial Amount, the time period used to determine the Medicare Share fraction is based on data from the latest filed 12-month cost report at the time the calculation is made, and that is later updated when the first 12-month cost report for the hospital fiscal year that begins after the beginning of the payment year is settled.

The numerator of the Medicare Share is the **sum** of:

◆ The estimated number of acute care inpatient-bed-days attributable to individuals for whom payment may be made under Part A; and

◆ The estimated number of acute care inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage organization under Part C.

The denominator of the Medicare Share is the **product** of:

◆ The estimated total number of acute care inpatient-bed-days for the eligible hospital during such period; and

◆ The estimated total amount of the eligible hospital's charges during such period, not including any charges that are attributable to charity care, **divided by** the estimated total amount of the hospitals charges during such period.

*Note: The removal of charges attributable to charity care in the formula, in effect, increases the Medicare Share resulting in higher incentive payments for hospitals that provide a greater proportion of charity care. The amount comes from the Medicare Cost Report, Worksheet S-10.*

## Transition Factor

The third factor in the formula to determine the incentive payment to an eligible hospital for a payment year is the Transition Factor. As seen in Table 2, this element phases down the incentive payments over time.

Hospitals that demonstrate that they are meaningful users of certified EHR technology in FYs 2011, 2012, or 2013 could receive up to four years of financial incentive payments. Hospitals that begin receiving incentive payments later than FY 2013 will receive no more than three years of incentive payments. Specifically, if a hospital were to begin to demonstrate meaningful use of certified EHR technology in FY 2014, it would receive incentive payments for FY 2014, FY 2015, and FY 2016. Similarly, if a hospital were to begin meaningful use of certified EHR technology in FY 2015, it would receive incentive payments for FYs 2015 and 2016. Table 2 shows the possible years an eligible hospital could receive an incentive payment and the Transition Factor applicable to each year.

**Table 2: Fiscal Year That Eligible Hospital First Receives the Incentive Payment**

| Fiscal Year | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|
| 2011 | 1.00 | | | | |
| 2012 | 0.75 | 1.00 | | | |
| 2013 | 0.50 | 0.75 | 1.00 | | |
| 2014 | 0.25 | 0.50 | 0.75 | 0.75 | |
| 2015 | | 0.25 | 0.50 | 0.50 | 0.50 |
| 2016 | | | 0.25 | 0.25 | 0.25 |

## Scenarios

The following scenarios illustrate how the Medicare hospital incentive payments are calculated each year. Each scenario is meant to show the differences in the incentive payments based on the number of discharges for a year, the percentage of charity care, and the year in which the hospital begins receiving an incentive payment.

### *Examples*

### *Hospital A*

Hospital A becomes a meaningful user and is eligible for incentive payments beginning in FY 2011. Hospital A had 1,000 acute care inpatient discharges in FY 2010 (the latest filed 12-month cost report). Also, in FY 2010 it had 3,000 Part A acute care inpatient-bed-days and 4,000 Part C acute care inpatient-bed-days. Its total acute care inpatient-bed-days in FY 2010 were 10,000.  Hospital A's total charges excluding charity care were $2,700,000, and its total charges for the period were $3,000,000. Based on this information, Hospital A received a preliminary incentive payment of $1,560,000 for being a meaningful user of certified EHR technology in FY 2011. Its incentive payment was calculated as follows:

**Initial Amount – $2,000,000 (Hospital A did not have more than 1,149 discharges)**
**Medicare Share – 0.78 = ([3,000 + 4,000] divided by [10,000 x (2,700,000/3,000,000)])**
**Transition Factor – 1**
**Preliminary Incentive Payment – $2,000,000 x 0.78 x 1 = $1,560,000**

The hospital's final payments would be based on hospital discharge data and Medicare Share data from the cost report that begins after the beginning of the payment year and determined at the time of settlement for that cost reporting period.

## *Hospital B*

Hospital B becomes a meaningful user and is eligible for incentive payments beginning in FY 2014. Hospital B had 12,000 acute care inpatient discharges in FY 2013 (the latest filed 12-month cost report). Also in FY 2013 it had 20,000 Part A acute care inpatient-bed-days and 16,000 Part C inpatient-bed-days. Its total acute care inpatient-bed-days in FY 2013 were 45,000. Hospital B's total charges excluding charity care were $8,000,000, and its total charges for the period were $9,000,000. Based on this information, Hospital B received a preliminary incentive payment of $2,814,885 for being a meaningful user of certified EHR technology in FY 2014. Its incentive payment was calculated as follows:

**Initial Amount – $4,170,200 (Hospital B received an additional $2,170,200 for the 10,851 discharges after its 1,149th discharge)**
**Medicare Share – 0.9 = ([20,000 + 16,000] divided by [45,000 x (8,000,000/9,000,000)])**
**Transition Factor – 0.75**
**Preliminary Incentive Payment – $4,170,200 x 0.9 x 0.75 = $2,814,885**

The hospital's final payments would be based on hospital discharge data and Medicare Share data from the first 12-month cost report that begins after the beginning of the payment year and determined at the time of settlement for that cost reporting period.

## *Hospital C*

Hospital C becomes a meaningful user and is eligible for incentive payments beginning in FY 2015. Hospital C had 25,000 acute care inpatient discharges in FY 2014 (the latest filed 12-month cost report). Also in FY 2014 it had 40,000 Part A acute care inpatient-bed-days and 23,000 Part C acute care inpatient-bed-days. Its total acute care inpatient-bed-days in FY 2014 were 75,000. Hospital C's total charges excluding charity care were $26,750,000, and its total charges for the period were $28,000,000. Based on this information, Hospital C received a preliminary incentive payment of $2,802,976 for being a meaningful user of certified EHR technology in FY 2015. Its incentive payment was calculated as follows:

**Initial Amount – $6,370,400 (Hospital C received the highest discharge-related amount allowed by law because it had more than 23,001 discharges)**
**Medicare Share – 0.88 = ([40,000 + 23,000] divided by [75,000 x (26,750,000/28,000,000)])**
**Transition Factor – 0.50**
**Preliminary Incentive Payment – $6,370,400 x 0.88 x 0.50 = $2,802,976**

The hospital's final payments would be based on hospital discharge data and Medicare Share data from the first 12-month cost report that begins after the beginning of the payment year and determined at the time of settlement for that cost reporting period.

## Additional Resources

For more information on the EHR incentive program, see *http://www.cms.gov/EHRIncentivePrograms/* on the CMS website.

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**ICN# 904626 (November 2010)**

# EHR Incentive Program for Critical Access Hospitals

The American Recovery and Reinvestment Act (Recovery Act) of 2009 provides for incentive payments beginning in federal fiscal year (FY) 2011 for eligible critical access hospitals (CAHs) that are meaningful electronic health record (EHR) users. According to Section 1861 (mm)(1) of the Social Security Act, a CAH is defined as a facility that has been certified as a critical access hospital under section 1820(c). Additionally, CAHs may also be eligible for incentive payments insofar as they qualify as an acute care hospital under the Medicaid portion of the EHR Incentive Payments Final Rule. For purposes of the Medicaid EHR Incentive Program only, CAHs are treated exactly like acute care hospitals (e.g., must meet patient volume and are subject to the same incentive payment calculation as Medicaid acute care hospitals, not the special calculation listed below). The rest of this document talks about the special provisions for CAHs under the Medicare EHR Incentive Program.

CAHs that adopt a certified EHR system and are meaningful users can begin receiving incentive payments in any year from FY 2011 to FY 2015. However, in no case will a CAH receive an EHR incentive payment for more than four years.

While the law defines a payment year in terms of a federal fiscal year beginning with FY 2011, a CAH does not have to begin receiving incentive payments in FY 2011. CAHs can begin receiving payments in any year from FY 2011 to FY 2015; however, the number of years for which the CAH will be eligible to receive an EHR incentive payment will decrease for CAHs that demonstrate meaningful use and begin receiving incentive payments in FY 2013 and later. CAHs that are not meaningful users of certified EHR technology beginning in FY 2015 will be subject to payment adjustments.

## Incentive Payment Calculation

Regardless of the payment year, the incentive payment is the **product** of the following:

1. **The reasonable costs for the purchase of a certified EHR system**
2. **The Medicare Share plus 20 percentage points**

## Reasonable Cost

For purposes of determining a CAH's EHR incentive payment, reasonable cost is based on any costs incurred for the purchase of a certified EHR system during the cost reporting period and any similarly incurred costs from previous cost reporting periods to the extent that they have not been fully depreciated as of the cost reporting period involved. Reasonable cost includes acquisition costs, excluding any depreciation and interest expenses related to the acquisition, incurred for the purchase of depreciable assets such as computers and associated hardware and software necessary to administer certified EHR technology.

## Medicare Share

For CAHs, the formula for the Medicare Share is as follows:

$$\frac{\text{\# of IP Part A Bed Days} + \text{\# of IP Part C Days}}{\text{Total IP Bed Days} \times \left[ \dfrac{\text{Total Charges - Charges Attributable to Charity Care}}{\text{Total Charges}} \right]} + 20 \text{ percentage points}$$

IP=inpatient

The second step in determining the incentive payment for a meaningful user of certified EHR technology is to calculate the Medicare Share and then add 20 percentage points.

The numerator of the Medicare Share is the **sum** of:

◆ The estimated number of inpatient-bed-days attributable to individuals for whom payment may be made under Part A; and

◆ The estimated number of inpatient-bed-days attributable to individuals who are enrolled with a Medicare Advantage Organization under Part C.

The denominator of the Medicare Share is the **product** of:

◆ The estimated total number of inpatient-bed-days for the eligible CAH during such period; and

◆ The estimated total amount of the eligible CAH's charges during such period, not including any charges that are attributable to charity care, **divided by** the estimated total amount of the CAH's charges during such period.

Data on the CAH's Medicare fee-for-service and managed care inpatient-bed-days, total inpatient-bed-days and charges for charity care taken from the CAH's most recently filed 12-month cost report at the time of the calculation will be used as the basis for making preliminary incentive payments. Final payments will be determined at the time of settling the cost report for the CAH's fiscal year that begins during the payment year and settled on the basis of the CAH data from that cost reporting period. For example, for an eligible CAH with a cost reporting period running from July 1, 2010 through June 30, 2011, CMS would employ the relevant data from the CAH's most recently filed 12-month cost report (most likely the cost reporting period ending June 30, 2010) to determine the incentive payment for the CAH during FY 2011. However, the final incentive payment would be based on CAH data from the cost report that begins July 1, 2011 (fiscal year ending June 30, 2012), and determined at the time of settlement for that cost reporting period.
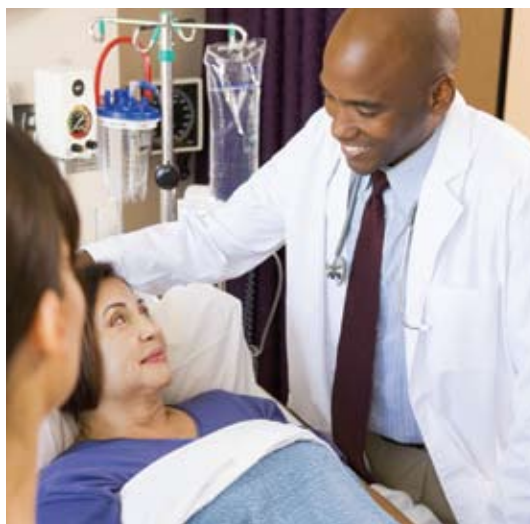
Once the Medicare Share is determined, 20 percentage points are added to the number to arrive at the final factor in determining the total CAH payment.

## Program Timeframe

CAHs may begin receiving incentive payments in any fiscal year beginning in FY 2011 and ending in FY 2015; however, CAHs cannot receive an incentive payment for a cost reporting period that begins in a payment year after FY 2015. This means that CAHs that demonstrate that they are meaningful users of certified EHR technology in FY 2011 or 2012 could receive up to four years of financial incentive payments. CAHs that begin receiving incentive payments later than FY 2012 will not be eligible to receive the full four years of incentive payments. Those CAHs who first receive an incentive payment for FY 2013 would only be eligible for three years of incentive payments. Likewise, CAHs that begin to demonstrate meaningful use of certified EHR technology in FY 2014 would only receive incentive payments for FY 2014 and FY 2015 and those who begin in FY 2015 would only qualify for an incentive payment for that year.

For FY 2016 and beyond, payment to CAHs for the purchase of additional EHR technology will be made under § 413.70(a)(1) in accordance with the reasonable cost principles that include the depreciation and interest costs associated with the purchase.

## Reduction of Reasonable Cost

If a CAH has not demonstrated meaningful use of certified EHR technology for FY 2015, the CAH's reimbursement will be reduced from 101 percent of its reasonable costs to 100.66 percent. For FY 2016, reimbursement will be reduced to 100.33 percent of its reasonable costs. For FY 2017 and each subsequent fiscal year, reimbursement will be reduced to 100 percent of reasonable costs.

However, a CAH may, on a case-by-case basis be exempted from this adjustment if the CAH can demonstrate, on an annual basis, that becoming a meaningful user of EHR technology would result in a significant hardship. In no case will a CAH be granted an exemption for more than five years.

*Note:  More information on payment adjustments and the requirements to qualify for a hardship exemption will be provided in future rulemaking prior to the 2015 effective date.*

## Scenarios

The following scenarios illustrate how the CAH incentive payments are calculated each year.  Each scenario is meant to show the differences in the incentive payments based on the CAH's reasonable costs and the Medicare Share.

### *CAH A*
CAH A becomes a meaningful user and is eligible for incentive payments beginning in FY 2012.  CAH A also incurred reasonable costs of $500,000 for the purchase of certified EHR technology during the previous cost reporting period. The CAH depreciated $100,000 of the costs of these items in the previous cost reporting period, leaving $400,000 of undepreciated costs.

On its most recently filed 12-month cost report, CAH A had 300 Part A inpatient-bed-days and 400 Part C inpatient-bed-days, and its total inpatient-bed-days were 1,000. CAH A's total charges excluding charity care were $2,000,000, and its total charges for the period were $2,200,000. Based on this information, CAH A received a preliminary incentive payment of $388,000 for being a meaningful user of certified EHR technology in FY 2012. Its incentive payment was calculated as follows:

**Medicare Share – 0.97 = ([300 + 400] divided by [1,000 x (2,000,000/2,200,000)]) + 20 percentage points**

**Preliminary Incentive Payment – 400,000 x 0.97 = $388,000**

The CAH's final payment would be based on Medicare Share data from the cost report that begins during the payment year and determined at the time of settlement for that cost reporting period.

### *CAH B*

CAH B becomes a meaningful user and is eligible for incentive payments beginning in FY 2014. CAH B incurred reasonable costs of $350,000 for the purchase of certified EHR technology during the previous cost reporting period. The CAH depreciated $50,000 of the costs of these items in the previous cost reporting period, leaving $300,000 of undepreciated costs. In FY 2014 the CAH also incurred reasonable costs of $200,000 for the purchase of certified EHR technology that will not be depreciated.

On its most recently filed 12-month cost report, CAH B had 6,000 Part A inpatient-bed-days and 3,000 Part C inpatient-bed-days, and its total inpatient-bed-days were 14,000. CAH B's total charges excluding charity care were $8,000,000, and its total charges for the period were $9,000,000. Based on this information, CAH B received a preliminary incentive payment of $460,000 for being a meaningful user of certified EHR technology in FY 2014. Its incentive payment was calculated as follows:

**Medicare Share – .92 = ([6,000 + 3,000] divided by [14,000 x (8,000,000/9,000,000)]) + 20 percentage points**

**Preliminary Incentive Payment – $500,000 x 0.92 = $460,000**

The CAH's final payment would be based on Medicare Share data from the cost report that begins during the payment year and determined at the time of settlement for that cost reporting period.

## Additional Resources

For more information on the EHR incentive program, see *__http://www.cms.gov/EHRIncentivePrograms/__* on the CMS website.

<u>Rural Wisconsin Health Cooperative Recommended Narrative for the IRS Form 990</u>

Each rural hospital is unique and depending upon a hospital's distance from another hospital, the supplemental narrative text below may make more or less sense to include in a rural hospital's IRS Form 990, Schedule H, Part VI.

This perspective <u>is not</u> intended to justify a hospital avoiding the responsibility of having a robust investment in the diverse array of activities catalogued in various statewide community benefits reports; rural hospitals must do all they can to help their communities become healthier. <u>It is</u> intended to help educate our country about the real value of rural hospitals in case of a future regulatory use of the 990s.

Recommended Narrative (must be edited to reflect the hospital's individual situation):

 "While there is growing agreement in the United States about what constitutes a non-profit hospital's 'community benefit,' this is a work in progress. Our hospital provides significant charity care and other community benefits as defined by the IRS. But in addition, we believe that we provide a critically important community benefit which is not quantified. Our hospital, like most rural hospitals, was created and is maintained in order to provide care locally–care that without our hospital, would not be available locally."

"Beyond inpatient hospitalizations, we provide local access to many health services: Ambulance Services, Birthing Center, Dialysis Center, Diagnostics, Emergency Services & Urgent Care, Extended Care, Home Care, Hospice, Infusion Services, Inpatient Care, Laboratory Services, Occupational Health, Rehabilitation Services, Specialty Medicine, Sleep Center, Speech and Audiology, Surgical Services, Women Services."

11-14-08

**National Center for Rural Health Works**
**Improving the health of rural communities**

**Community Health Needs Assessment Tool Kits Available Free Online**

"The National Center for Rural Health Works has provide community health needs assessment for many years. The "OLD" process is the **Community Health Engagement Process (CHEP)** and is still a very viable assessment tool. **CHEP** is illustrated below with attachments that explain the process in detail and the products developed with this tool."

"With the passing of "The Patient Protection and Affordable Care Act" in 2010, all 501(c)(3) hospitals (not-for-profit or non-profit hospitals) must conduct a community health needs assessment (CHNA) process to meet the U.S. Department of Treasury and Internal Revenue Service (IRS) rules. The "NEW" process is a more streamlined process, referred to as the **Community Health Needs Assessment (CHNA) toolkit**. The **CHNA toolkit** was developed over the last year by the National Center. The **CHNA toolkit** is illustrated below in detail. The **CHNA toolkit** will enable hospitals to conduct the process themselves or allow other organizations to facilitate the process for the hospitals. The **CHNA toolkit** includes the documents for each product in their original formats, i.e., Microsoft Word, Excel, and/or Powerpoint, in order for the documents to be easily utilized and replicated."

"Either process may be utilized and can fulfill the new legislative requirements. **CHEP** has more detailed products, typically more meetings, and derives community input through a phone survey conducted by an outside contractor (higher costs). The **CHNA toolkit** has more streamlined products, fewer meetings, and options for community input that include focus groups or surveys. The analysis of the community input method is typically performed locally to avoid the high costs of a telephone survey."

The tool kits are available at **http://ruralhealthworks.org/chn/**

# Rural Hospitals. Healthy Communities.

## *A Look at RWHC's Member Hospitals impact…*

Incorporated in 1979 as the Rural Wisconsin Hospital Cooperative, RWHC has received national recognition as one of the country's earliest and most successful models for networking among rural hospitals. The National Rural Health Association, the National Cooperative of Health Networks and the Wisconsin Hospital Association have given RWHC their top award available to an organization or program. Today, the work continues as the renamed Rural Wisconsin Health Cooperative responds to rural hospitals' increasingly diverse role in their communities.

In addition to providing quality health care, RWHC Member Hospitals also contributes to the local economy by supporting other local businesses through "multiplier effects" that are generated in three ways:

- The hospital's purchases create industry revenues for local businesses and "indirect" jobs and income for their employees.

- Employee purchases generate "induced" income and jobs for other businesses in the community.

- Wages and salaries are subject to federal, state and local taxes.

## What are the RWHC Member Hospitals Impact on Wisconsin?

- *Provides jobs for 13,714 hospital workers and supports an additional 8,431 jobs created indirectly for a total of 22,145 jobs.*

- *Accounts for $2,545,292,044 in economic activity. The direct effect of RWHC Hospitals is $1,652,186,896.*

- *Contributes $1,218,987,441 in total income to the community.*

- *Provides $112,853,002 in total uncompensated care.*

The Vision of RWHC is that rural Wisconsin communities will be the healthiest in America. We believe that rural hospitals can help make healthy lifestyles a trademark of their communities–improving health status, reducing avoidable health care utilization and helping to attract and retain jobs. Rural Wisconsin has extra challenges. Rural counties are typically the least healthy in a state, particularly compared to suburban communities and small cities. We believe that hospitals, clinics, public health agencies and employers working together in rural communities can help employees, their families and their communities become healthier.

Data Source: http://www.wha.org/economic-impact.asp

| Job Impact of *RWHC Member Hospitals* | |
|---|---|
| Direct Jobs | 13,714 |
| Indirect/Induced Jobs | 8,431 |
| **Total Jobs** | **22,145** |

| Impact of *RWHC Member Hospitals* on Wisconsin Economy | |
|---|---|
| *Revenue (Gross Income)* | |
| Direct Impact | $1,652,186,896 |
| Indirect/Induced Impact | $893,105,148 |
| **Total Impact** | **$2,545,292,044** |
| *Labor Income (Wages & Benefits)* | |
| Direct Impact | $652,298,112 |
| Indirect/Induced Impact | $257,307,599 |
| **Total Impact** | **$909,605,711** |
| *Total Income (Labor Income + Net Income)* | |
| Direct Impact | $740,666,394 |
| Indirect/Induced Impact | $478,321,047 |
| **Total Impact** | **$1,218,987,441** |

# Population Health Improvement and Rural Hospital Balanced Scorecards

Tim Size, MBA;[1] David Kindig, MD, PhD;[2] and Clint MacKinney, MD, MS[3]

Now is the time for balanced scorecard–driven strategic planning to incorporate population health measures. The growing expectation of health care purchasers, in rural and urban America alike, regarding health improvement and health care costs suggests that health care providers join with public health and other community leaders to "look upstream" for opportunities to prevent illness and reduce future health care expenses. Community leadership must act, and hospitals are part of that leadership.

The Institute of Medicine (IOM) of the National Academies of Science, in its November 2004 report, *Quality Through Collaboration: The Future of Rural Health*,[1] highlights a unique opportunity for rural health:

> Residents of rural America are diverse, but one thing they generally do have in common is a strong sense of attachment to their community. This community orientation, combined with the smaller scale of rural health, human services, and community systems, may afford rural communities an opportunity to demonstrate more rapidly the vision of balancing and integrating the needs of personal health care with broader community-wide initiatives that target the entire population.[1(p55)]

The balanced scorecard is a practical performance improvement tool that rural hospitals are increasingly integrating into their strategic planning and management processes. The goal of the balanced scorecard is to link strategy with action and to identify cause/effect relationships among short- and long-term objectives. Robert Kaplan and David Norton helped to popularize the balanced scorecard in the early 1990s, and they organized key objectives into 4 domains or perspectives: customer, internal, innovation and learning, and financial.[2] Since then, strategic planning consultants and hospital leaders have been adapting, applying, and evolving the tool for health care.

The term population health has been defined as follows:

> the health outcomes of a group of individuals, including the distribution of such outcomes within the group. These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups, disabled persons, or prisoners. Such populations are of relevance to policymakers. In addition, many determinants of health, such as medical care systems, the social environment, and the physical environment, have their biological impact on individuals in part at a population level.[3]

Many hospitals across the country have long been involved in key community-wide interventions—this is not new. However, the concept of including local population metrics in a hospital's balanced scorecard is challenging because hospitals, not unlike other community organizations, are not solely responsible for their communities' health. As best expressed by a rural hospital chief executive officer during a focus group discussion at the Rural Wisconsin Health Cooperative in early 2004, when rural population health care outcomes are everyone's responsibility, they are, as a practical matter, no one's responsibility.

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[3]Stroudwater Associates, Portland, Maine.

The IOM in its 2002 report *Fostering Rapid Advances in Healthcare: Learning From System Demonstrations* stated, "The healthcare system of the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal healthcare with broader community-wide initiatives that target the entire population."[4] That the time is right for rural America to address this fundamental challenge is at the heart of the IOM's *Quality Through Collaboration: The Future of Rural Health*. In this report, the IOM went further than *Fostering Rapid Advances*, emphasizing the increasingly critical need for America to adopt this integrated approach and citing the unique advantages and major role rural communities can have in leading the way.[1(p55)] That is the opportunity.

Although the disciplines of population health analysis and balanced scorecard–based management are well established, the 2 have not previously been considered together. Furthermore, rural hospitals may accept an implicit and informal role in community health, but that role may be easily subjugated by the more pressing demands of revenue-generating activity. As they are often the de facto local health care system leader, and are now subject to an increasing private and public sector demand for nonprofit hospital accountability, rural hospitals may be ready to assume a greater role in population health improvement.

Based on findings from 2 focus groups of rural hospital executives and senior staff held at the Rural Wisconsin Health Cooperative in early 2004, rural barriers to hospitals taking on this expanded role appear to fall into 2 sets, strategic and technical. First among the strategic barriers is tradition. With some notable exceptions, the role of the hospital has been seen as treating individual patients. Concern about the population as a whole has been seen as "the job" of local and state public health departments, notwithstanding that sector's chronic underfunding. The second strategic barrier is obvious—rural hospitals and clinics that are struggling to address traditional responsibilities with tight budgets are not looking for new roles "that no one will pay us to do." The third is the conflict or discomfort that most of us in rural America feel when talking about addressing population health issues, some of which relate to individual behaviors—other people's choices and their freedom to make those choices. The fourth is a general lack of appreciation, in rural and urban communities alike, of the multiple determinants of health beyond medical care, including education, income, and the environment.

Population health improvement has long been the purview of public health departments, not hospitals. Despite its noble mission, public health in the United States has long lived in the shadow of traditional medical care (provided by physicians and nurses to individuals in hospitals and clinics). Although the causal relationship between funding and outcomes is complicated and often obscure, our public health outcomes are discouraging compared to those of other industrialized countries spending far less per capita. Why is that so? The answer must be multifactorial. However, the United States, particularly the rural United States, is a culture of "rugged individualism." Additionally, a fascination with technology and an expectation for quick fixes challenge the most basic public health endeavors. We undermine public (or community) health right out of the gate. In rural communities already challenged by smaller scales and fewer resources, the local hospital has emerged as a key potential locus for community-based health care. It need not necessarily be that way, but in the hospital are strong potential resources—preferably in partnership with public health professionals, leaders in education and economic development, and local physicians—to foster population health improvement efforts. Thus far, this new potential hospital role as population health improver is an uncomfortable fit.

We need to emphasize that the issue is not whether or not rural hospitals should be in charge but whether or not rural hospitals have a collaborative leadership role to play—along with other key players in the community: the local public health agency, local businesses, clinicians, schools, employers, etc. In some rural communities, a hospital may play a facilitator or convener role, but in no communities should this be about the hospital "taking charge" of the community's health. Even if you could find a hospital that wanted that role, the nature of the work requires community-wide collaborations to get the job done. Similarly, this is not a competition between individualism and a community focus but creating a synergy between 2 important frames—personal health and population health.

We often think of Americans as individualists, but our country's tradition is more complex than the well-worn aphorism for rural life, "good fences make good neighbors," first lets on. Robert Frost's poem "Mending Wall" goes on to say, "I let my neighbor know beyond the hill, and on a day we meet to walk the line and set the wall between us once again." Even this American icon to rural self-sufficiency is expressed within the cultural context of selective cooperation being used to maintain individualism.

Rural physicians also have an important potential role in rural community health; yet, this role is not fully supported. Physicians have 4 primary responsibilities: to prevent illness, to cure disease, to comfort the dying, and to be a wise steward of resources. In reality, the resource steward responsibility often becomes lost in the first 3. Physician socialization rightly reinforces individual patient advocacy but often does so regardless of the cost burden placed on the population (a pool of potential patients). Health care, as provided in the United States, is costly beyond any international comparison; rural health care is no exception. What better investments might we make to improve rural health? A more balanced investment portfolio in the multiple determinants of population health improvement might bring us better value for the dollars spent. Thus, to turn the ocean liner of cultural individualism and physician socialization to embrace a need for community thinking, we need to understand that our vast investments in health care provide only modest returns in population health. We need a new focus on population health *in concert with* a continued focus on personal health. A bilateral approach is critical.

If cultural barriers to population health improvement were not difficult enough, technical barriers, while narrower in scope, remain challenging. Most metrics found to be useful for balanced scorecards are measured on a monthly or quarterly frequency. Consequently, results of interventions aimed at moving the data can be tracked and used to test intervention effectiveness, identify unintended consequences, and motivate change. In contrast, traditional population health metrics are available annually at best and typically represent a geographic area that does not align with a hospital service area. In rural service areas, the above barriers are further complicated by the statistical challenges of working with small numbers. We need new approaches to address these data gaps.

In addition, we need to link health improvement efforts to population health outcomes. This is one of population health's greatest challenges. Yet, we can use proxies for population health outcomes, such as, high blood pressure control for cardiovascular disease or HgbA1c rates for diabetes, 2 major problems for rural communities. Preventive quality indicators (previously ambulatory care sensitive conditions) measure hospital admission diagnoses that could have been avoided by good preventive care and have been tracked by the Rural Wisconsin Health Cooperative in collaboration with the state's quality improvement organization. In addition, certain statistical techniques may ameliorate the challenge of low-outcome incidence. A second challenge lies in how we define the boundaries of our communities. Should a hospital be responsible for the health of its community, county, or region? Researchers at Dartmouth have identified hospital and primary care service areas based on prior utilization. Yet, any definition of "community," and any population health improvement measure or effort, must include those individuals who have not yet accessed health care services. The above barriers are not insurmountable.

But we must come back to the overriding problem that when rural population health care outcomes are everyone's responsibility, they are, as a practical matter, no one's responsibility.

If some entity(ies) must step up and take leadership in the quest for optimal health, the health care sector has significant responsibility and opportunity—a responsibility, given the nature of the profession and the significant amount of public and private resources it is entrusted with (not to mention its legal community benefit responsibility), and an opportunity, given the trust that most people put in health care providers and organizations. If this is true, rural hospitals may have an opportunity to take a lead, given their smaller size, the general interrelatedness of the different sectors in rural areas (health care, education, social services, public health, local government), and the importance of the rural hospital and health systems in the local economy.

The very essence of balanced scorecards is that successful organizations focus on those objectives and related outcomes that if achieved go a long way to advancing the organization's vision. If organizational success is directly affected by measures of population health, hospitals will engage. But hospitals do not print money, and few rural hospitals have separate foundations with any substantial resources. The challenge is as it has always been, how do we pay for caring for today's patients while finding the funds to become more proactive to reduce the future health care needed?

The trick is to define the right level of responsibility for any one organization. Some have suggested that a new entity such as a health outcome trust take on the convening role.[5] As pay-for-performance models become more widespread, and as health outcomes begin to be purchased instead of just services, all of this will become much easier. We are beginning to see pay-for-performance developments in both medical care and education, but not yet rewards for health outcome improvement at the population level.

Exact models for health outcome trusts have not been developed or fully specified. Many "healthy community" partnerships are trying to do this, and enlightened state and local public health leaders

envision such a role for the new public health. What is required is a coordinated effort between the public and the private sectors, as well as financial resources and incentives to make it work. The task is almost certainly too big for voluntary efforts, particularly when producing health is viewed as involving hospitals, doctors, public health and environmental agencies, schools, and nonprofit advocacy groups. There may be more promise for such models being developed in rural areas where the relationships are already at a smaller and even personal scale. In such settings, hospitals are natural candidates for a leadership role, while clearly acknowledging that the full responsibility is beyond the hospital or medical care sector alone.

Where do we start? The 2004 IOM report *Quality Through Collaboration: The Future of Rural Health*.[1] gives important guidance for national and state initiatives. With or without the timely implementation of these recommendations, much can be done at the local level by rural hospitals to foster population health awareness and new collaborative interventions, such as follows:

- Devote a periodic board meeting or a portion of every board meeting to review available population health indicators.
- Add board members with specific interest and/or expertise in population health measurement and improvement, such as public health professionals, educators, and economic development experts.
- Create a "population health" subcommittee of the hospital board to explore opportunities for hospital partnerships with other community organizations to improve proactively population health.
- Consider hospital employees or employees of a proactive local employer as a "community" and develop

interventions to improve employee health. Then, expand the experience to the larger community.

Business schools cite railroads as a classic example of a sector's failure to adapt to changing times, falling from tycoon status in the late 19th century to bankruptcy in the 20th. The railroads kept on doing what initially had been a successful business strategy—selling access to rail cars and track. However, the railroads failed to adapt to a market that was redefining transportation as cars and airplanes, not trains. In a similar fashion, health care "markets" are being redefined, shifting from purchasing service units to purchasing quality outcomes. Importantly, quality care is increasingly defined in both personal and population perspectives. This developing redefinition of health care markets needs to be reflected in hospital strategic planning. This is a great opportunity for rural hospitals and the communities they serve.

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# BALANCING AND DIFFERENTIATING BETWEEN GOVERNANCE & ADMINISTRATION

## WHAT IS GOVERNANCE?

A thin, but important line separates the duties of the board of directors from those of the hospital chief executive officer (CEO). Understanding the distinction between the CEO's operational jurisdiction, and the board's governance duties, is a significant factor in a Critical Access Hospital's organizational success.

Governance is the process by which a board of directors ensures that an organization is run in the best interests of its stakeholders. The board sets the overall direction and goals of the hospital by:

- Adopting broad policies

- Making major decisions

- Selecting and evaluating the chief executive

- Evaluating company performance

Most hospitals don't have stockholders, but they do have stakeholders — individuals or groups that benefit from the hospital's quality services. Nonprofit hospitals are most often managed and operated by charity driven and faith-based organizations. As with school boards, trustees who serve on public hospital boards are expected to represent the interests of the city, county or district's taxpayers who supply the hospital with financial support.

A hospital's stakeholders can include its patients, families and the community at large. Stakeholders also include employees, physicians, businesses and other community health care providers, all of which have an interest in seeing the hospital succeed. Regardless of the size or type of hospital, there are many external parties to which trustees and the administrator share direct accountability.

An organization as complex as a hospital could never operate properly without a committed group of caring individuals, willing to make difficult decisions about the hospital's future. That is governance at its core. The hospital board is the group tasked with assimilating input received from stakeholders, and then directing the organization to meet the needs of those to whom it is accountable. They serve as the conduit between the hospital and the community.

Effective governance requires the CAH board to:

- Focus on where the hospital is going and how the board will know when it gets there

- Develop a positive and dynamic relationship with the CEO

- Set policy, direction and strategy, but never engage in management activities

- Encourage each trustee to share and contribute their talents and skills to the board and the hospital

- Create an environment of respect and cooperation where trustees can be truthful, ask meaningful questions, speak their concerns and resolve differences

- Invest in two-way communication with the medical staff

- Listen to and hear one another

- Perform an annual board self-evaluation

Remembering the roles and responsibilities of hospital trustees, and staying focused on strategic issues, can help the board provide better oversight and accountability to the population it serves. Governance is a learning process that takes time to perfect. Trustees should continually seek out resources and educational opportunities that expand their familiarity with the complexities of the industry and their role as trustees.

Governing by instinct, rather than by proven governance practices, can lead to dangerous lapses in judgment. Instead, showcase good governance by helping ensure that objectives are realized, resources are managed appropriately and stakeholder interests are being met.

## THE DIFFERENCE BETWEEN POLICY AND OPERATIONS

Policies are guiding principles or recommended courses of action that direct current and future decision making. Operations include all activities related to the day-to-day management of the facility and staff. The board sets the policy for the hospital, while management implements it. Implementation is, therefore, the administrator's responsibility.

Very complex organizations, like hospitals, develop countless administrative policies without board involvement. These policies include personnel, budgeting, spending and other operational issues. Tasks such as these are best left to the CEO and other executives who are well-versed on the issues and needs of patients and staff. No board that is properly fulfilling its role would want to be involved in such details.

Experienced trustees limit their involvement to broad policy matters. They spend much of the time developing the long-term objectives they envision the administrator working to achieve. Establishing clear direction and formally adopted policies on important matters helps trustees steer clear of operations by articulating the guidelines for operational decisions that are the CEO's primary responsibility.

Therefore, the chief executive and board members are interdependent. Ideally, they operate in a harmonious, symbiotic way. However, disharmony and agitation can result when the thin line that separates these critical responsibilities is intentionally or repeatedly undermined.

## THE POWER OF THE BOARD

Governing boards bear the ultimate responsibility for the organization. They must directly or indirectly represent the interests of every hospital stakeholder in an unbiased manner. The board selects an effective chief executive officer and monitors the organization's ongoing performance. The board also defines the organization's mission and vision, and develops the long-range strategic plan for achieving that vision. It is the administrator's most important task to implement the strategic plan successfully.

## THE CEO DEPENDS ON THE TRUSTEES

The administrator is selected by the trustees, and receives management authority from the board. However, the CEO should never view the board and its responsibilities as merely a legal requirement. Most trustees choose to serve out of a genuine interest for the well-being of the hospital and its stakeholders, and the CEO should value the board's collective wisdom.

## TRUSTEES DEPEND ON THE CEO

The board must depend on the CEO to show leadership. That includes putting together a successful team of executives and staff, and helping trustees use their volunteer time most effectively. The chief executive is a vital source of knowledge and education that trustees need to fulfill their fiduciary obligation. Boards turn to the CEO for information on operations, financial performance and quality patient outcomes.

## COMPARISON OF CHIEF EXECUTIVE OFFICER AND BOARD OF TRUSTEES ROLES

| Trustees | Chief Executive |
|---|---|
| Act as a group | Individual |
| Concentrate on the long term | Concentrates on shorter term |
| Mainly concerned with policy and strategy | Mainly concerned with implementation of the board's plans |
| Permanent and continuous | Temporary |
| No staff | Access to all staff |
| Ultimate responsibility | Limited responsibility |
| Typically not experts in the field | Professional; typically expert |
| Volunteer their time | Paid a salary |
| Only an overview of the organization | Intimate knowledge of organization |

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## SUMMARY

Trustees are focused primarily on governance. Trustees work as one cohesive unit and should not allow themselves to be subdivided by the CEO, hospital staff or become involved in issues that don't require their involvement. They should instead be focused on long-term objectives and work at the policy level, never at an operational level. This means they shouldn't interact directly with staff, but come to rely on the CEO as the hospital staff's collective voice.

Despite the fact that individual trustees might not have much, if any, experience in the health care industry, the board is accountable for the actions of the CEO as well as the success of the entire organization. However, this commitment doesn't need to be a burden. There is tremendous satisfaction in knowing that the hospital provides life-saving health care services for the community. By becoming educated on trustee-related hospital issues, maintaining broad oversight and setting a positive tone for the organization, trustees can help make their vision a reality.

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# BUILDING A STRONGER BOARD/CEO RELATIONSHIP

No question — today's health care environment is challenging. Critical Access Hospital CEOs and their management teams are working harder than ever, yet often with a sense of dissatisfaction. Regulations are increasing, but margins are declining. Efforts to remain in compliance and reduce costs also have reduced employee morale. New facilities are needed and qualified health care professionals are in short supply. The list of unsolved problems makes it difficult to celebrate the many good things being accomplished.

This reality places significant stress on board/CEO relationships. Board members wonder, does the CEO possess the leadership skills the job demands? CEOs worry if their board has the mix of talent and experience required to govern the organization in such turbulent times. More than ever, the complexities of managing today's hospital demand a strong, positive working relationship between board members and their CEO.

By focusing attention on the maintenance of a positive working relationship with the CEO, you can nurture the investment that is one of, if not the most important factors, of success at your hospital. Experience has shown that rapid turnover at the CEO level causes turmoil and creates a leadership void that diverts attention away from the strategic vision that the board has set for the organization. Let us now consider what actions you can take to maintain your most important source of human capital.

## BUILDING THE BOARD'S RELATIONSHIP WITH THE CEO

The foundation for a sound board/CEO relationship begins with a clearly defined long-range vision and strategic direction for the hospital. The vision should be realistic in light of the business environment. However, craft a long-range vision that challenges the organization's leadership to stretch and explore new ways of doing things. Clearly delineate organizational priorities and, given the noted resource constraints, identify initiatives that are not achievable in the foreseeable future.

Sometimes, in order to remain viable, the hospital must increase revenue through focused, disciplined growth or enhancement of services. Don't be afraid to invest resources in new services that can generate positive margins. To do so will require a willingness to take risks, to make and tolerate some mistakes, and to learn from those mistakes. Recognize that these decisions may generate increased conflict and be prepared to manage it.

## FOCUS ON LONG-RANGE VISION

It is well within the CEO's job, with full encouragement and support from the board, to provide leadership in shaping the vision, defining priorities, and creating a true sense of momentum and forward action. While the CEO may lead this process, it cannot be done alone.

The input and involvement of physicians, board members and other key stakeholders ensures that they understand and support the hospital's strategic direction. Expect the CEO to demonstrate a commitment to building and promoting an organizational culture grounded in trust and credibility. This will certainly increase the likelihood of a successful implementation process.

The CEO has a right to expect certain things from the board as well. Among them, the board should:

- Commit to excellence in governance
- Add value to the decision-making process
- Focus on policy-level issues, not operational concerns
- Communicate clear expectations to both the CEO and medical staff leadership, and hold them accountable for their performance
- Be the hospital's advocate in the community
- Actively support the CEO, especially when the hospital faces new challenges


## THE CHAIR IS THE BOARD'S PRIMARY CONTACT WITH THE CEO

One way to build a stable environment for good board/CEO relations is to utilize the board chair as the primary or central point of contact. The chair and the chief executive need to support, consult and complement each other. Both have their own responsibilities — the CEO manages the operational activities and the chair leads the board. They share power in their mutual pursuit to advance the mission of the organization.

To make this happen, open and regular communication is the key. This partnership needs constant attention. Personalities change but these positions remain. Each partner needs to adapt to and cultivate the working relationship. Think of the chief executive as the gatekeeper for the staff and the chair as the gatekeeper for the rest of the board. This helps prevent miscommunication or over-communication and allows both leaders to stay aware of the needs that each of the other's constituents may have.

## SOME IMPORTANT GROUND RULES FOR EFFECTIVE BOARD-CEO RELATIONSHIPS

- The board's expectations of the CEO and of itself should be clearly articulated, and they should not change every time the chair or complexion of the board changes.

- The CEO should be empowered to operate as the single point leader within the organization — not requiring the board's permission to act, yet demonstrating the ability to keep the board well informed.

- The CEO should be a voting member of the board and an ex-officio member of all board committees. The board should not hold executive sessions without the CEO present, except as part of the performance review process.

- The CEO should work in collaboration with the board chair to ensure sound governance and the on-going professional development of the board.

- The CEO should write goals and objectives that are updated annually and approved by the board at the beginning of each fiscal year.

- The CEO evaluation process should be conducted by a committee, not by the chair alone. The CEO's salary and benefits should be reviewed and approved by the full board.

- The healthy board/CEO relationship is one that is grounded in mutual respect, honest and open dialogue, a willingness to disagree, and mutual support.


## UNHAPPY BOARD/CEO RELATIONSHIPS: WARNING SIGNS

Some hospitals do seem to have a 'revolving door' where upper management is concerned. This often results from a lack of trust between the board and CEO. The delicate balance of trust and oversight must be fostered in order for a hospital to successfully address its obligation to the community. CEOs respect trustees that are open and honestly interested in seeing the hospital succeed. CEOs and trustees must respect each other's autonomy and focus on their own spheres of influence. Here are some "red-flag" situations to watch for:

- A board that engages in micro-managing, rather than concentrating on long-term issues and can't seem to leave the implementation and day-to-day management to the staff

- A chief executive who controls the agenda, filters information and frustrates the trustees' efforts to set policy and plans

- A board that has an unreasonable set of expectations and then offers little in the way of guidance or support

- A board that is fractious and has trouble making decisions or articulating a unified vision for the hospital

## SUMMARY

CEO and board tenure is a major feature of many successful hospitals. Along with this tenure comes experience, institutional knowledge and a healthy respect for the many complexities that are common to the hospital business. It also helps to build a tremendous amount of trust and respect when a group of individuals has remained engaged during even very difficult times.

However, relationship building must not ebb just because times are good. The board and CEO should continually look for new ways to improve communication and enhance interaction. Unfortunately, many administrators don't even realize they are out of step with the board of directors until they are suddenly asked to resign. While CEO recruitment is a critical board function, building a relationship that fosters CEO retention is where much of the board's time and energy should more effectively be spent.

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# BOARD RECRUITMENT, SELECTION & EVALUATION

Unlike other rural hospitals, Critical Access Hospitals (CAHs) must meet certain criteria to participate in the Critical Access Hospital program. However, there is no difference between the responsibilities and functions of a CAH board member and those of any other rural hospital board member.

## BOARD RECRUITMENT AND SELECTION

A board should consist of individuals with a variety of skills and expertise, occupations, ages and backgrounds. Prospective board members also should be well connected within their communities.

Board members must have the time, commitment and interest in serving on the board, and they must be able to work well with a diverse group of colleagues. Before recruiting new board members:

- Identify the skills and attributes needed on the board

- Identify the skills and attributes of current board members

- Develop selection criteria for new board members

- Recruit prospective candidates

- Build a commitment for them to serve

## BOARD PROFILING

It is also helpful to create a profile of the existing board. Focus on characteristics such as:

- Age

- Sex

- Race or ethnicity

- Residence

- Occupation

- Governance experience

- Industry and market knowledge

- Clinical expertise

- Financial knowledge

- Management experience

- Experience with acquisitions and mergers

- Community and political contacts

Use the Board Profile Worksheet (Figure 1) to compile information. Once completed, the worksheet provides a clear picture of the current board's attributes, and the skills and criteria needed to complement the existing board members.

## BASIC BOARD MEMBER SELECTION CRITERIA

Begin narrowing the pool of prospective candidates by focusing on basic selection criteria. These include such things as:

- Willingness to serve

- Sufficient time and energy to do an effective job

- Willingness to participate in board orientation and ongoing continuing education activities

- Objectivity

- Integrity

- No serious conflicts of interest

- Values consistent with those of the hospital's mission, goals and objectives

Only individuals meeting these basic criteria, as well as any additional criteria developed by the hospital board, should apply for board positions.

## SUPPOSE MY BOARD IS EITHER ELECTED OR ADVISORY?

In some cases, the hospital may have little choice in who serves on the board. For instance, hospital district boards run for office, and proprietary hospital boards often are appointed by the parent corporation. However, regardless of the type of ownership, community leaders have an opportunity — in fact, an obligation — to recommend qualified and viable candidates for board positions. This holds true whether the board is selected through local elections, appointed by a corporation with headquarters located out of town, or selected through a self-perpetuating process. Once the board profile and new board member criteria have been adopted, it is incumbent upon the existing board leadership to promote candidates who will best serve the interests of the hospital, its patients and the community.

## NEW BOARD MEMBER SELECTION CRITERIA

Some of the new board member selection criteria which may be adopted include:

- Past Board experience

- Professional and business experience

- Demonstrated leadership skills

- Record of community involvement and commitment

- Political involvement or connections

- Skills and competencies aligned with the strategic direction of the hospital

- Experience in a specific occupation

Other criteria for new board members may be adopted, dependent upon the specific needs of the organization.

## RECRUITMENT METHODS AND TIPS

Try the following suggestions for recruiting board members:

- Share the skills and attributes desired for board member candidates with both existing board members and community leaders, so that both parties can help identify viable candidates

- Ask advisory boards and/or community members on board committees to help identify and recruit new board members

- Hold candidate forums

- Share prospective board member qualifications with the community at large

- Invite community leaders to the hospital to see if future new board members emerge in the process

## BOARD ORIENTATION AND CONTINUING EDUCATION

Conduct an orientation for every new board member. Focus on the hospital's unique organizational characteristics, and discuss the expected functions and responsibilities of board members.

Continuing education for board members is also an important tool in helping members better understand hospital programs and services, industry and technological changes, financing and the delivery of care. Tools for continuing education include board manuals, committee activities, article review, board retreats and trustee conferences.

## QUALIFICATIONS FOR TERM RENEWAL OF BOARD MEMBERS

The re-election or reappointment of board members should be determined based upon how well the member:

- Contributes at board and committee meetings

- Prepares for each board meeting

- Supports board actions, and does not push personal agenda items

- Avoids conflicts of interests, states potential conflicts, and abstains in voting on such issues or matters

- Carries out committee and board duties as assigned

- Communicates effectively with key constituents

- Works well with other board members


## THE ROLE OF THE BOARD CHAIR

A good board chair is essential to effectiveness of a hospital board. This is especially true on smaller boards, where the board chair may cast the deciding vote or preside or mediate over contentious matters. The board chair's most important functions are to:

- Preside over all meetings of the board and executive committee

- Designate committee chairs, with the advice and consent of the executive committee

- Serve as an ex-officio member of all board committees (not expected to participate)

- Serve as the board's primary representative to key stakeholder groups

- Serve as counselor to the CEO on matters of governance and board/CEO relations

In addition, the chair and executive committee:

- Specify annual board objectives

- Approve board meeting agendas

- Help recruit, develop and act as mentors to other board members

A strong and influential board chair can make a significant difference in the overall effectiveness of the hospital's operations.

## BOARD SELF-EVALUATION AND PERFORMANCE

All hospital boards are responsible for evaluating their own level of performance, as well as that of the hospital and its CEO. As the policy-making body for the hospital, the board sets the tone for evaluating performance by conducting a factual and candid annual performance self-assessment.

A successful board self-assessment will:

- Objectively assess the level of common trustee understanding, expectations and direction

- Facilitate goal setting

- Pinpoint organizational improvement opportunities

- Help senior management understand the board's educational development needs

- Build broad consensus-based trustee decisions

- Create opportunities to address major issues and ideas in a non-threatening, collaborative manner

Six key steps in the self-assessment process include:

1. Developing and gaining consensus on the board's performance criteria
2. Conducting the assessment through a thorough, anonymous written survey
3. Summarizing the assessment results and reporting back to the full board
4. Engaging in a dialogue about the meaning and implications of the key findings
5. Identifying specific leadership improvement opportunities
6. Creating a board work plan for implementation of the board's direction

The criteria for board self-assessment may vary somewhat from hospital to hospital. Adopt a method most meaningful to the hospital's specific needs. Make board self-assessment a continuous process, documented annually. Include appropriate follow-up actions for needed improvements in the board's functioning. CAH hospitals can contact Texas Healthcare Trustees for Sample Board Self-Assessment Questionnaire as a guide in developing their own forms.

### SUMMARY

A diverse, committed group of directors is essential to an effective Critical Access Hospital. The key is to understand the characteristics needed in each board member and recruit members who possess those selection criteria. Once on the board, trustees need continual education, clearly defined responsibilities, good communication and ongoing opportunities to assess their performance individually and collectively.

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## FIGURE 1
## BOARD PROFILE WORKSHEET

| Name of Board Members | | | | | |
|---|---|---|---|---|---|
| Age | | | | | |
| Sex | | | | | |
| Race or Ethnicity | | | | | |
| Residence | | | | | |
| Occupation | | | | | |
| Governance Experience | | | | | |
| Industry and Market Knowledge | | | | | |
| Clinical Expertise | | | | | |
| Financial Knowledge | | | | | |
| Management Experience | | | | | |
| Experience with Acquisitions and Mergers | | | | | |
| Community and Political Contacts | | | | | |

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# Leadership Development for Rural Health

*Tim Size*

Rural health has come a long way, but has a long way to go. With hindsight, some might minimize Jim Bernstein's leadership, now unaware that much of what he did for rural health was initially just an idea, a hope. It is this midwifing of a vision into reality that is the very essence of leadership. Henry David Thoreau described Jim's caliber of leadership when he wrote the oft repeated lines, "If a man does not keep pace with his companions, perhaps it is because he hears a different drummer. Let him step to the music which he hears, however measured or far away."[1] Jim Bernstein leaves a legacy that continues to challenge all of us to care and to achieve more than we first thought possible, whomever our drummer, whatever our position.

On July 15th, 2005, the National Advisory Committee on Rural Health and Human Services advisory to the Secretary of the United States Department of Health and Human Services, adopted a Special Resolution to honor James Bernstein, which concluded with the following: "The Committee believes that the best way to honor Jim is to consciously work to help develop the next generation of rural health leaders. Jim was a master of creating change by working within the existing policy framework and helping others to build sustainable programs that addressed long-standing problems. The Department should play a lead role by developing a program that identifies emerging leaders from and for rural communities and provides them with the training and resources to play a lead role in ensuring access to quality healthcare in their states and communities. This program warrants long-term support by the Department, and it should focus on rural needs within the larger policy context that affects us all. The Committee urges the Secretary to take the lead on this initiative, which will serve as a reminder of all of Jim Bernstein's fine work."[2]

While I can see/hear Jim wincing at the focused personal attention, I know he would put up with it to help further develop rural health, a process that must include understanding our past. I believe he would also be the first to remind us of the many people who are called to exercise leadership in both large and small ways.

This commentary is a personal statement without presuming to be writing the definitive word on what we need to know to further develop rural health leadership. My intent is to express belief as belief and not individual belief as universal truth, a convention too common today in our national "dialogue." The reader is invited to engage with what he or she reads here, taking what might be useful, and hesitating a moment to think through what might be useful, but doesn't immediately seem so. This is a "conversation," not a lecture.

## What Is Leadership Development and Why Do We Need It?

The weekend I received the opportunity to write this commentary, our church was celebrating those living or dead who made a contribution to our faith and various communities. That service brought forth the image that individuals who exercise leadership are like a river's current—a part past where we now stand, a part yet to come. We have an ongoing need to remember and to look toward the next "generation." Rural leaders will arrive without the assistance of any of us, but deliberative leadership development will foster more effective and diverse leadership. A key responsibility of those here now is to mentor and to create structures for mentoring, in order to maximize the flow and effectiveness of tomorrow's leaders.

Leadership is the capacity to help transform a vision of the future into reality. This commentary focuses on *leadership* development more than *leader* development to emphasize that throughout our organizations and communities, we have and need individuals who may not be formally designated as leaders, but who can and do exercise leadership. Leaders recognize that none of us are called

*"Leaders recognize that none of us are called to always lead, that sharing or conceding leadership to others is also a key role."*

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to always lead, that sharing or conceding leadership to others is also a key role. None of us are called to lead on every issue; all are called to interact and support the vision and ideas brought by others.

We need to recognize that in addition to individuals having the potential to exercise leadership, the potential of leadership also exists "corporately," in groups of individuals, whether they are teams, organizations, or communities. Individually and collectively, at all levels, we are called to lead in one place or another and are "born" with traits that can both enable and interfere with that opportunity and responsibility. Wherever the individual or group starts, learning and growth are possible. We need to structure leadership development for groups and communities as well as individual leaders.

Leadership development, formal or informal, is not just for the chronologically young. I have a friend who for many years has been a newspaper reporter and columnist as well as the chaplain for a mission that works with our city's poor and addicted people. He has arrived at "retirement" age, but many of his readers are now seeing a columnist who speaks with a profoundly clearer voice. Some of the paper's readers who disagree with him would undoubtedly welcome the news of his retirement; so be it, leadership necessarily brings out in good measure both supporters and detractors.

Leadership comes in many contexts. Jim Bernstein and I talked more than once about the similarities and differences in our vocational situations. We held in common that we were born and raised "elsewhere," but became deeply rooted in our adopted home states. I work with mid-western rural communities facing relatively more racial homogeneity and less extreme poverty. These communities have a strong tradition of agricultural cooperatives that enabled our development of a cooperative of community hospitals—hospitals that work with and challenge both our state and our universities. Jim worked with southern rural communities facing more racial diversity and often extreme, community-wide poverty. He was able to be innovative from a position inside of government. Jim was notable in the respect and understanding he offered those working in a variety of circumstances.

A friend recently shared with me a few of the leadership challenges she faces, which are unique to her role as the chief executive officer of a hospital in a rural community. This commentary will not catalog such challenges, but her comments serve as a reminder for the "in the trenches" reality that rural health leadership development initiatives must address. "It is easy to become isolated, I am the only person doing what I do in our community. We are much smaller than most of our urban counterparts, so I need to juggle the crunch of many required 'to dos' without the luxury of additional staff who can take the ball from start to finish. And when first arriving, it was not unusual to have a 'new gal/guy in our community trying to tell us what to do' type greeting. 'She or he will be gone and never give us another thought.' "

## The Role of Nature and Nurture

At one time, people tended to believe that leaders were born, not made. Now we tend to see leadership as a set of traits that can be nurtured. But what about nature, the traits we are born with? A while back, I was asked when I became an advocate. The answer was that we all receive some traits at birth, or shortly thereafter. "One of my most vivid memories of home in the late 1950s is the endless kitchen argument with my devout Baptist mother on the theory of evolution. Her particular tenacity on this issue may be traced to her childhood memories of her guardian's friend, William Jennings Bryan, the famed attorney on the then winning side of the 'Scopes Monkey Trial.' But like many women of her generation raised in the shadow of the old south, she had a finely tuned nature of smiling and cajoling while not giving an inch."[3] On the way to the rest of my life, I realized that what we did have in common was an innate passion to talk, and to never concede. Yes, nature matters, but it need not be determinative. Subsequently, with the help of a very well-financed Kellogg leadership program, others were able to teach me not to use a rhetorical cannon when a rifle was sufficient, and that once in a while, a concession wouldn't kill me.

America has a complex heritage when it comes to how it thinks about leaders—accepting contradictory leadership styles. We call the strong, individualistic characters, such as played by John Wayne, classic American leaders. Democrats and Republicans honor Jimmy Carter's leadership, whose less autocratic emphasis on partnership makes him a contender for "the country's most successful ex-President." We understand that leadership is not limited to the classically cinema-charismatic or those holding formal power, as Rosa Park's "simple" act of saying "no" will forever testify.

How our culture holds these apparent contradictions is not well understood. Robert Frost's poem "Mending Wall" set on a New England farm is most famous for the line "Good fences make good neighbors," a frequent citation of American individualism. But it is a better example of not reading a whole poem. Frost goes on to say, "I let my neighbor know beyond the hill, and on a day we meet to walk the line and set the wall between us once again…." Even this icon to self-sufficiency is expressed within the cultural context of selective cooperation.[4]

To develop as a leader, we must understand how leadership has unfolded in our own lives. A key initial transition is to recognize and accept "for better, for worse" what characteristics one has "hard wired" and then begin to see how one can develop further. This is also a precondition for those intending to take on the role of leader recruiter or mentor.

In my own development, a key step forward happened in my mid-20s while working as an "assistant superintendent" at a university hospital. As quickly as a light switch is turned on, I was lucky one day to realize that maximizing program successes was not the same as minimizing program failures. This eventually led to a transition from state government, which I experienced as being risk adverse, to an organization in the non-profit sector, which has allowed calculated risk taking. The operative word is

"I experienced." Jim Bernstein is the obvious counter example, having taken many risks and had many successes from a base within state government.

Risk taking requires comfort with failure, one of life's most powerful teachers. A while ago, I was asked to address how I maintain energy in the face of so many failures. I was taken off guard because I didn't think of myself as having had that many failures. Upon reflection, I was able to easily come up with a list of ten failures, many of which in less charitable circumstances would have involuntarily led me to "pursue a new career opportunity." I just hadn't been keeping a tally, and I still don't.

For us to have integrity as leaders, we have to continue to work to know who we are as we relate to our work. A timeless illustration is found in Chinese philosopher Chuang Tzu's "Woodcarver," written about 2,300 years ago:

> Khing, the master carver, made a bell stand
> Of precious wood. When it was finished,
> All who saw it were astounded. They said it must be
> The work of spirits.
> The Prince of Lu said to the master carver:
> "What is your secret?"
>
> Khing replied: …
> "What happened?
> My own collected thought
> Encountered the hidden potential in the wood;
> From this live encounter came the work
> Which you ascribe to the spirits."

The best explanation of this poem I know is in Parker Palmer's renowned work on vocation, an *Active Life*:[5]

> …we both act and are acted upon, and reality as we know it is the outcome of an infinitely complex encounter between ourselves and our environment. In this encounter we do some shaping, to be sure, but we are also shaped by the relational reality of which we are a part. We are part, and only part, of the great community of creation. If we can act in ways that embrace this fact, ways that honor the gifts we receive through our membership in this community, we can move beyond the despair that comes when we believe that our act is the only act in town…. When authentic action replaces unconscious reaction, the active life becomes not (in the words of Chuang Tzu) 'a pity' but a vital and creative power.

As noted by Parker Palmer, how we choose to frame or understand our relationship with others and our environment is critical to our growth as leaders. My best example occurred in graduate school, or more specifically in the dormitory elevator in graduate school. It was Chicago's oldest and slowest Otis elevator—it took an "eternity" to go the 12 stories to my room. One day it hit me that my frustration wasn't the result of the elevator, but my unrealistic expectation of its behavior. Subsequently, I still thought it was slow, but I didn't worry

about it. So how do we frame rural health leadership? What kind of elevator is it? If we make the right investments, what kind of elevator can it become?

## Servant Leadership and Rural Health

The concept of "servant leadership" is a perspective held by many throughout the rural health community, and I believe is a major frame for understanding the attributes of leadership we need in rural health. Robert Greenleaf, the man who coined the phrase servant-leadership described it as "the servant-leader is servant first…. It begins with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead."[6] I don't believe he is saying "natural" as in the sense "natural athlete," but that at some point in life, the feeling arises to serve, which in turn leads to a decision to exercise leadership. What are the attributes of servant leadership; what characteristics or skills must we look for when we recruit a leader or should we look for when we learn, teach, and reinforce? For me, a good start to that question is to compare the attributes of "servant" and "traditional" leaders. Cooper McGee and Duane Trammell do just this in "Hero as Leader to Servant as Leader."[7]

Examples of Traditional Leadership Skills

- Highly competitive; independent mindset; seeking personal credit.
- Understands internal politics and uses them to win personally.
- Focuses on fast action.
- Controls information in order to maintain power.
- Accountability is more often about who is to blame.
- Uses humor to control others.

Examples of Servant Leadership Skills

- Highly cooperative, interdependent; gives credit to others generously.
- Sensitive to what motivates others to win with shared goals and vision.
- Focuses on gaining understanding, input, buy-in from all parties.
- Shares big-picture information generously.
- Most likely listens first, values others' input.
- Accountability is about making it safe to learn from mistakes.
- Uses humor to lift others up.

## Our Health Needs Collaborative Leaders

I had the opportunity to serve on the national Institute of Medicine's (IOM) Committee on the Future of Rural Health Care. For me, the major breakthrough in the Committee's work as documented in the report, *Quality Through Collaboration: the Future of Rural Health*,[8] was that the IOM's Six Quality Aims (originally constructed for the healthcare of the individual) apply equally well to a population health perspective, or said another way, "the community as patient."

This perspective that we need to "balance and integrate personal healthcare with broader communitywide initiatives that target the entire population,"[9] developed after the committee applied the IOM report, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*,[9] to rural health. Examples of applying the IOM's Six Quality Aims for a population health perspective include:

- *Safety*: Road construction designed to reduce auto accidents.
- *Effectiveness*: Public schools act to reduce risk of obesity/diabetes.
- *Community-centered*: Regional provider networks respect community preferences.
- *Timeliness*: Timely identification of epidemics.
- *Efficiency*: Public reporting of population-based measures of health status.
- *Equity*: Developing, maintaining rural jobs.

The Committee on the Future of Rural Health Care synthesis was that "rural communities must build a population health focus into decision-making within the healthcare sector, as well as in other key areas that influence population health. Most important, rural communities must reorient their quality improvement strategies from an exclusively patient- and provider-centric approach to one that also addresses the problems and needs of rural communities and populations."[8] This vision constitutes a major opportunity for rural health leaders to lead the health of our country, all of it. The "central thesis" of the recently published compendium *Reinventing Public Health, Policies and Practices for a Healthy Nation* makes the same point "to effectively improve population health and reduce health disparities, policy making in a variety of domains must take into account policies that address the fundamental social, economic, and ecological determinants of health."[10]

As an example, in Wisconsin, a voluntary coalition has developed a Strong Rural Communities Initiative (SRCI) to support the state's health plan by implementing sustainable rural models for medical, public health, and business collaboration to enhance preventive health services in rural Wisconsin. In *Wisconsin County Health Rankings 2005*,[11] a report by the Wisconsin Public Health and Health Policy Institute at the University of Wisconsin-Madison, 52% of metro counties in Wisconsin are in the top (best) quartile for Health Outcomes compared to only 11% of non-metro counties; 30% of non-metro counties are in the bottom (worst) quartile compared to 16% of metro counties. The specific purpose of SRCI is to improve health indicators for selected rural communities in Wisconsin and significantly accelerate establishing collaboration for prevention as the norm, not the exception, in rural Wisconsin.

The complexity of creating a healthy state requires a higher level of cooperation than any of us have yet experienced. This requires a significant expansion in our commitment and ability to develop collaborative leadership. Again, from *Quality Through Collaboration: the Future of Rural Health*:[8]

Strong leadership will be needed to achieve significant

improvements in health and healthcare in rural communities. Comprehensive community-based efforts will require extensive collaboration, both between stakeholders within the healthcare sector, and between healthcare and other sectors. It will be necessary to mobilize all types of institutions (e.g., healthcare, educational, social, and faith-based) to both augment and support the contributions of health professionals. Rural communities engaged in health system redesign would likely benefit from leadership training programs.[8]

## Principles of Collaborative Leadership

The significant challenges we face today in healthcare require a form of leadership that is less authoritative and more collaborative. Ronald Heifitz and colleagues at the Stanford Graduate School of Business say it very well. These "problems require innovation and learning among the interested parties, and, even when a solution is discovered, no single entity has the authority to impose it on the others. The stakeholders themselves must create and put the solution into effect since the problem is rooted in *their* attitudes, priorities, or behavior. And until the stakeholders change their outlook, a solution cannot emerge."[12] It is important to not confuse being collaborative with endless stanzas of singing "Kum By Ya;" collaboration frequently requires strong external catalytic action.

Max DePree, in *Leadership Is an Art*,[13] offers a model for employer-to-employee relationships based on his experience that productivity is maximized by designing work to meet basic employee needs. His vision of the art of corporate leadership brought employees into the decision-making process. DePree's experience is primarily within the world of the Fortune 500, but many have found him to offer a useful framework for non-profit and public sectors.

While DePree was a successful leader of a Fortune 500 Company, some may describe him as impractical, a common descriptor thrown by the "pragmatists" at "collaborators." Robert Greenleaf offers a suggestion that may be helpful in thinking through this dilemma: "For optimal performance, a large institution needs administration for order and consistency, and leadership so as to mitigate the effects of administration on initiative and creativity and to build team effort to give these qualities extraordinary encouragement."[14]

As the executive director of a cooperative of rural hospitals for more than 25 years, it is easier for me than for many to see rural health through the lenses of collaboration, the opportunities it creates, and the threats it endures as a model for organization and community work. We have adopted and adapted DePree's eight leadership principles as a guide for both our internal and external relationships. To illustrate these leadership principles, the following is as described in the article "Managing Partnerships: The Perspective of a Rural Hospital Cooperative."[15]

*There Is Mutual Trust*—Develop relationships based primarily on mutual trust so that the cooperative go beyond the minimum performance inherent in written agreements. "While responding

to a rapidly changing market in 1984, the implementation in six months, 'from scratch,' of a rural-based health insurance company in Wisconsin was only possible due to the prior existence of a basic level of trust among the key actors."

*Commitment Makes Sense*—Participants may join a cooperative to explore its potential; they remain only if they perceive that they are receiving a good return on their investment of time and money. "RWHC offers a broad array of shared services from which hospitals pick and choose according to their individual needs; commitments are made because they have been structured in a way that attempts to maximize the 'fit' for each individual participant."

*Participants Needed*—Each organization must know that it is needed for the success of the cooperative. "It is a major mistake to ever take for granted the participation or commitment of any member. The RWHC communication budget is ample testimony to the importance of early and frequent communication and consultation."

*All Involved in Planning*—The planning is interactive, with the plan for the Cooperative being the result of, and feeding into, the plans of the individual participants. "One theatrical but powerful example of ignoring the need for local input and preferences involved the Cooperative within months of its incorporation in 1979. Two regional health planners were practically driven from the bare wood stage of Wisconsin's historic Al Ringling Theater after their presentation of a unilaterally developed plan for local consolidations and closures. The plan was not implemented and did not contribute to further discussion of how rural healthcare in southern Wisconsin could be improved."

*Big Picture Understood*—Participants need to know where the organization is headed and where they are going within the organization. "RWHC has a motto: 'say it early and keep saying it.' A number of RWHC's more significant initiatives, such as improving rural hospital access to capital, various quality improvement projects, and advocacy for major education reform within the University of Wisconsin's health professional schools has been multiyear if not indefinitely long efforts."

*Participants Affect Their Own Future*—The desire for local autonomy needs to be made to work for the Cooperative through the promotion of collaborative solutions that enhance self-interest. "When RWHC began operations, many observers were highly skeptical about whether or not it would last, let alone make any real contribution—that rural hospitals' traditional need for autonomy would prevent any meaningful joint activity. Some shared services have been undersubscribed as hospitals have chosen local options when, at least from the perspective of RWHC staff, a cooperative approach offers a better service at a lower cost."

*Accountability Up Front*—Participants must always know up front what the rules are and what is expected of them. "Discussions at RWHC board meetings are frequently comparable to customer focus groups and equally valuable. Participation in all Cooperative shared services requires a signed contract, not so much as to permit legal enforcement, but to ensure that all parties in the partnership have thought through upfront the expectations of all the participants."

*Decisions Can Be Appealed*—A clear non-threatening appeal mechanism is needed to ensure individual rights against arbitrary actions. "The use of the cooperative strength of RWHC hospitals has been used to enforce an appeals process in a variety of circumstances, including a potential breach of contract by a large health insurer; individually, few could have justified the necessary prolonged legal challenge to enforce the contract but through concerted joint inquiry into the legal options available, further legal action became unnecessary."

## Recruiting Rural Health Leaders

When recruiting organizational leaders, the recruitment and interview process must seek individuals who in addition to technical competence, also have demonstrated leadership in their prior work and activities. John Gardner, in his classic work, *On Leadership*,[16] notes six characteristics common to individuals who exercise organizational leadership. These characteristics are exhibited in many roles, for example, as the head of an organization, as a manager, or in a volunteer position:

- They think longer term—beyond the day's crises, beyond the current fiscal year.
- In thinking about the program or organization they are heading, they grasp its relationship to the larger organization or community—conditions external to the organization.
- They reach and influence constituents beyond their immediate area of responsibility.
- They emphasize the intangibles of vision, values, and motivation and understand intuitively the non-rational and unconscious elements in their relationship with their constituents.
- They have the political skills to cope with the conflicting requirements of multiple constituents and expectations.
- They think in terms of renewal. The leader or leader/manager seeks procedural and structural change consistent with an ever-changing reality.

In addition, as argued throughout this commentary, collaboration needs to be a core competency for leadership of those organizations claiming to work in or with rural communities. The following are a few examples of principles relevant to collaboration to keep in mind or discuss when recruiting or developing a leader.

*Collaborative Leadership Isn't Always Traditional*—If leadership is serious about maintaining and developing collaborative relationships, the following must be kept in mind:

- Management practices necessary for successful collaboration are not commonly seen in traditional, vertically organized institutions.
- Most administrators have had little experience, and even less training, regarding leadership within the context of collaborative models.
- The "natural" administrative response will frequently come out of traditions that may be inconsistent with the actions needed to support networking.

- The development of collaborative relationships has a different timescale than those based on authority—more time on the front end paid off later with less participant resistance.

*Personal Attributes of a Collaborative Leader*—A partial list of the personal attributes relevant to seeking or developing a collaborative leader include:

- Experience/potential for leading collaborative enterprises or networks, cultural competence across diverse communities and populations.
- When looking at alternative investments: the objectivity of an academic, the pragmatism of a businessman or woman, and the creativity of an artist.
- Appreciation for the dualities inherent in American culture—individualism and community, competition and collaboration; a realistic understanding of the health system challenges we face balanced by an "irrational" optimism and faith that we each can make a difference.
- A vision that leadership needs to be simultaneously top down and bottom up within organizations, as addressed by Max DePree.

*Collaborative Leadership Skills and Experience*—Below are a set of general questions intended to stimulate conversation regarding an individual's collaborative leadership skills and experience.

- What is the role of "trust" in your work with colleagues or partners? What examples can you offer of your ability developing trust in these "partnerships"? How did you do it? How was the relationship affected?
- How have you been able to make your collaborative partners feel useful?
- How have community partners been invited into your organization? What did you see as benefits and challenges in these instances? How would you do it differently today?

- In what ways have you worked to promote collaborative solutions that have enhanced the self-interest of both internal and external partners?

## Summary

Leadership is the capacity to help transform a vision of the future into reality. Individuals who can and will exercise leadership are like a river's current—a part past where we now stand, a part yet to come. We have an ongoing need to remember and to look toward the next "generation." A key responsibility of those here now, is to mentor and to create structures for mentoring, in order to maximize the flow and effectiveness of tomorrow's leaders. When recruiting organizational leaders, the recruitment and interview process must seek individuals who in addition to technical competence, also have demonstrated leadership in their prior work and activities.
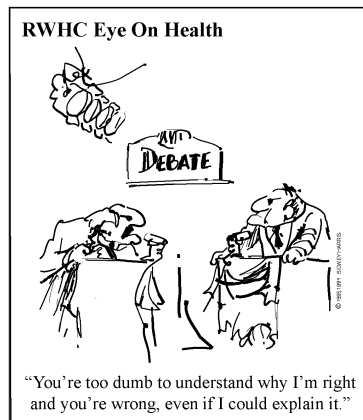
To exercise effective leadership, we must work to know who we are, how we relate to others, and the environment around us. "Servant leadership" is a perspective held by many throughout the rural health community and offers a key set attributes of leadership useful to rural health. To implement the Institute of Medicine's recommendations in *Through Collaboration: the Future of Rural Health*, we must develop leaders skilled in collaboration, both internal to their organization and across organizations.

The National Advisory Committee on Rural Health and Human Services had it right when they said to the Secretary and to the rest of us, "the best way to honor Jim is to consciously work to help develop the next generation of rural health leaders." There are, of course, a multitude of leadership institutes, programs, and courses throughout America; this is not a call for yet another separate entity. But it is a call to each of us in rural health to assure that we are deliberate in how we identify "emerging leaders from and for rural communities and provide them with the training and resources to play a lead role in ensuring access to quality healthcare in their states and communities."[17] Let's get started. **NCMedJ**

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# We All Need To Be Effective Advocates for Rural Health

**RWHC Eye On Health**

"You're too dumb to understand why I'm right and you're wrong, even if I could explain it."

Tim Size
Executive Director
Rural Wisconsin
Health Cooperative
Sauk City

February 14th, 2013

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## Why Advocacy Is Critical for Rural Health?

1. "Policies" are public laws/regulations and private sector rules/traditions that govern our behaviors and how dollars and resources are allocated.

2. Policies are often "urban-centric" due to bias and misinformation, rarely "anti-rural."

3. Ongoing rural advocacy needed to counter bias and correct the misinformation.

4. Strong rural advocacy needs engaged grass roots advocates (not just hired "lobbyists.")

## Presentation Outline: Five Take-Aways

1. Individual Context Matters
2. Rural Health Requires Myth Busting
3. Rural Health Does Not Stand Alone
4. Examples of Common Advocacy Challenges
5. There is an Art & Science to Advocacy

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## 1. RWHC's View of the World



**RWHC Eye On Health**

"Over Supply"          "No Supply"

RWHC                                                                4
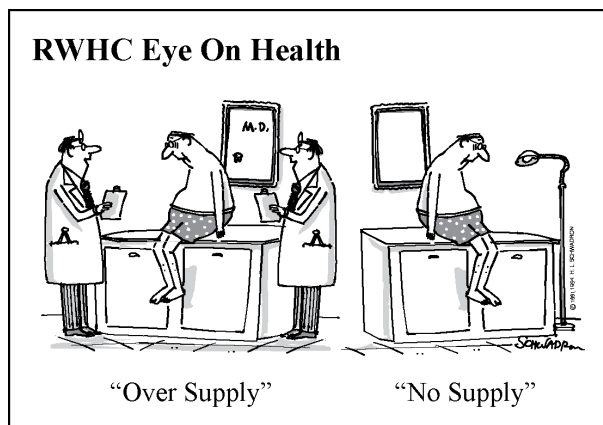
## Mission & Vision: RWHC Example

<u>Mission</u>: Rural WI communities will be the healthiest in America.

<u>Vision</u>: RWHC is a strong and innovative cooperative of diversified rural hospitals; it is (1) the "rural advocate of choice" for its Members and (2) develops & manages a variety of products & services.

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## Financial Drivers: RWHC Example

- Founded in 1979.

- Non-profit coop owned by 37 rural hospitals (with net rev ≈ $1.4B & 2,000 hospital & LTC beds).

- 8 PPS & 29 CAH; ≈ 23 freestanding and 14 system affiliated.

- ≈ 70 employees (50 FTE).

- ≈ $11M RWHC budget (75% member sales, 17% non-member sales, 6% dues & 2% grants).
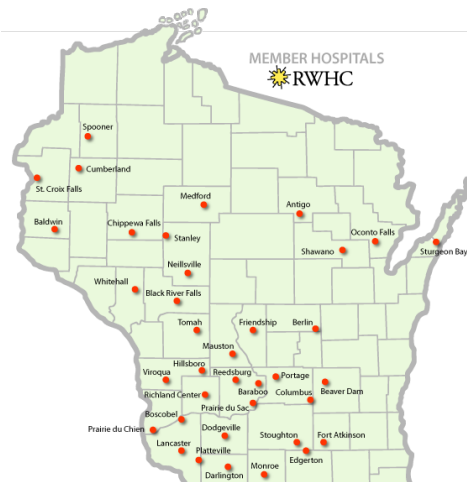
# RWHC Shared Services*

**Professional Services**
Financial & Legal Services      Negotiation with Health Insurers
Medical Record Coding           Clinical Services & Recruitment

**Educational**
Professional Roundtables & Leadership Training
Nurse Residency Program & Preceptor Workshops
Lean Lab (with Lean Six Sigma Master Black Belt)

**Quality Programs**
Credentials Verification & Peer Review Services
Quality Indicators & Improvement Programs

**Technology Services**
Data Center Services
Electronic Medical Records & Technology Management

*Partial List*

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# Strategic Partners: RWHC Example

- Cooperative Network
- Federal Office of Rural Health Policy
- La Crosse Med. Health Science Consort.
- Marquette University
- Medical College of WI
- MetaStar, Inc.
- National Cooperative of Health Networks
- National Rural Health Resource Center
- National Rural Health Association
- UW School of Medicine & Public Health
- UW School of Nursing
- UW School of Pharmacy
- WI Area Health Education Centers
- WI Center for Nursing

- WI Collaborative for Healthcare Quality
- WI Council on Workforce Investment
- WI Dept of Health Services
- WI Dept of Workforce Development
- WI Dept Safety & Professional Services
- WI Hospital Association
- WI Health & Ed. Facilities Authority
- WI Healthcare Data Collaborative
- WI Medical Society
- WI Office Rural Health
- WI Primary Care Association
- WI Public Health Association
- WI Rural Health Development Council
- WI Statewide Health Info. Network

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## External Opportunities: WI Example

- Typically in top five in the nation for quality
- Low rate of uninsured
- Low cost state in Medicare program
- High level of physician/hospital integration
- Robust adoption of HIT, esp. EHR
- WI has a good tort environment

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## External Threats: WI Example
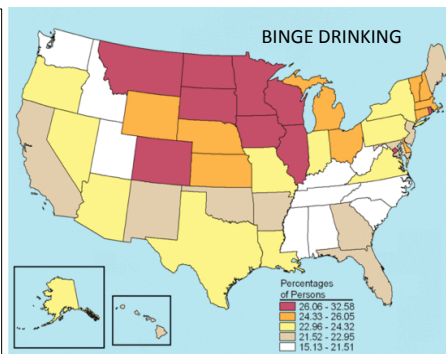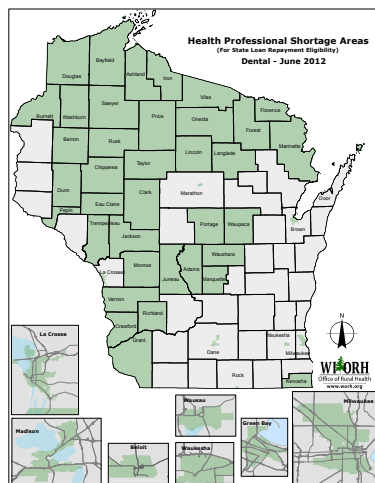


Many would say that changing these maps is not a priority of organized dentistry or the tavern league.

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## Context Drives RWHC Advocacy Agenda

1. Federal **Healthcare Reform** that recognizes rural realities.

2. Fair **Medicare and Medicaid** payments to rural providers.

3. **Federal and State regulations** that recognize rural realities.

4. **Retain property tax exemption** for nonprofit hospitals.

5. Solve growing **shortage of rural physicians and providers**.

6. Bring rural voice to **regional provider networks & payers**.

7. Bring a rural voice into the **quality improvement** movement.

8. Continue push for workplace and community **wellness**.

9. Strong link between **economic development** and rural health.

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## 2. Rural Health Requires Myth Busting

*\* Myth = widely held false belief*

- Rural residents don't want to get care locally.
- Rural folks are naturally healthy, need less.
- Rural health care costs are less than urban care.
- AND Rural health care is inordinately expensive.
- Rural quality is lower; urban is better.
- Rural hospitals are just band-aide stations.
- Rural hospitals are poorly managed/governed.



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## 3. Rural Health Does Not Stand Alone

**RWHC Eye On Health**

"You educate us for the jobs that gets us the income to stay healthy and out of his clinic which allows us to focus on getting educated to get..."
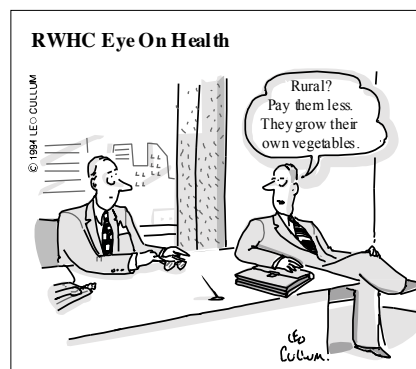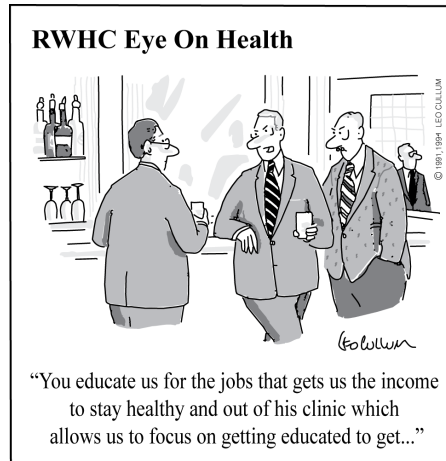
Rural health is about rural health and health care but it is necessarily also about rural; jobs, rural schools and vice versa.

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## Rural Health is an Export "Commodity"

• Local rural health = local health care jobs.

• People often know that business relocation decisions are influenced by the cost and quality of health care available locally.

• But as or more importantly, rural health has the same economic impact as export commodities like milk, soy beans or rural based manufactured goods because of its ability to bring dollars and jobs into the community.

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## Jobs in All Sectors Depend on Rural Health

- Rural insurance premiums and taxes only come back to circulate in the community and create jobs <u>if</u> there are local health care providers there (and people use them) to attract those dollars.

- For every 2 jobs created (or lost) in rural health care, the number of jobs in other local businesses increase (or decrease) by 1 job.

- **The rural economy is very dependent on <u>where</u> its health care dollars are spent.**

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## 4. Examples of Common Advocacy Challenges

RWHC Eye On Health

© 1994 AL ROSS

"No. Around here, I've never heard of any rural backwater or Lake Wobegon."

Unexamined Biases about Rural, Pro and Con.

(Illustrations from past issues of RWHC's monthly newsletter *Eye On Health*)

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Tradition Conceals Important Questions

RWHC Eye On Health

Dental Care Limited

"Why do we try not to chop off infected toes but we routinely pull out 'bad' teeth."
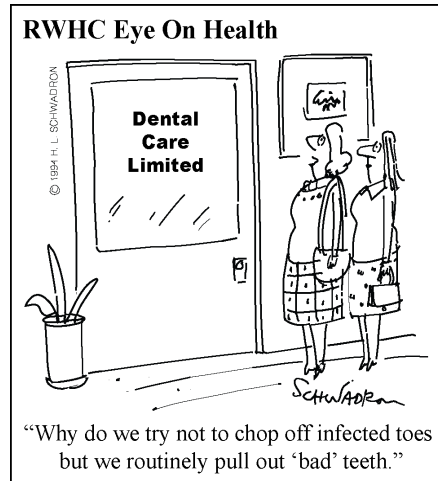


Politics Trump Policy & Research

RWHC Eye On Health

"Tell me again how this works for people to re-elect me."

Both public and private policy makers have constituencies that drive the process more than the best research.

## Rural Faces Challenge of Smaller Data Sets

**RWHC Eye On Health**

One solution to a "small numbers" problem.
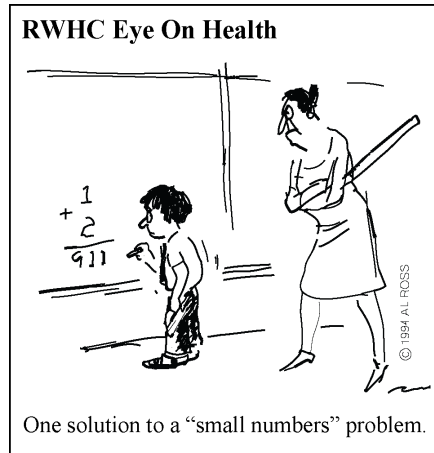
The increased focus on quality reporting and outcome metrics designed for large organizations creates a statisical challenge for many rural hospitals and physicians.

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## Fear Often Trumps Hope & Delays Change

**RWHC Eye On Health**

"We don't have to tackle healthcare reform until voters' hope of gain outweighs their fear of loss."
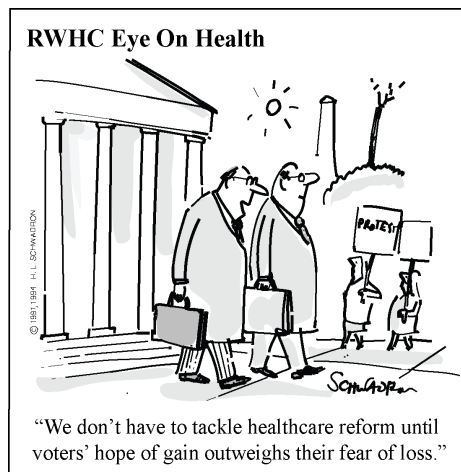
Machiavelli & Thomas Jefferson both understood that change required "that the hope of gain be greater than the fear of loss."

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## Don't Underestimate Economic Self Interest



## Elected & Appointed Officials Can Be At Odds

## 5. There is an Art & Science to Advocacy

Our legislatures and congress are not models of effective advocacy given the excessive partisan gamesmanship driven by astronomical fundraising & winner take all redistricting.



RWHC Eye On Health
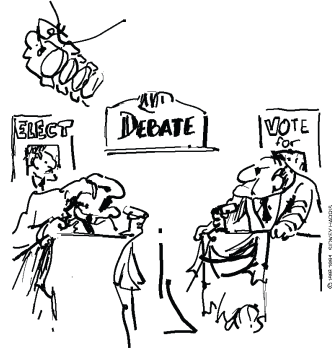
"I could agree with your position, if I wasn't raising money for reelection."

## A Key Driver of Dysfunctional Government



Fig. 6.4. Elkanah Tisdale's original Gerrymander, as it appeared in the Boston *Gazette*, March 26, 1812. (From James Parton, *Caricature and Other Comic Art* [New York: Harper and Brothers, 1877], p. 316.)

Senate approves new legislative districts
Republicans in the Senate approved redrawing the boundaries of legislative and congressional districts Tuesday on a 19-14 party-line vote.
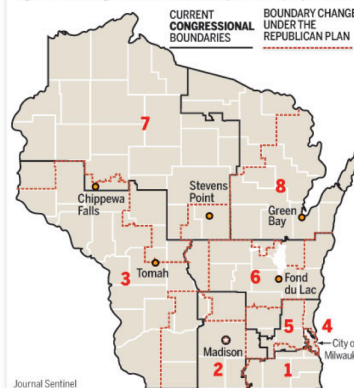
## Advocacy = An Ongoing Process/Cycle



UW Population Health Institute's "Take Action" cycle or Deming's widely known Plan-Do-Study & Act (Adjust) cycle work equally well for advocacy.

**The Rankings & Roadmaps Team Can Assist**
www.countyhealthrankings.org/roadmaps/action-center

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## What Drives Advocacy Cycles (Examples)?

- **Need to Correct Bias** (Critical Access Hospitals)
- **Opportunity to Reframe** (Binge Drinking)
- **Short-term Fix Possible** (Draft Regulations)
- **Broad Coalition Possible** (Workforce Data)
- **Address Core Need** (Physician Supply)
- **Anticipate Problems** (Insurance Exchanges)
- **Can't Be Avoided** (Healthcare Costs)
- **Long-term Need** (Healthier Communities)

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## Use a Three Prong Advocacy Strategy

**Make your best case**:  Concise, credible and fiscally responsible, but are easy to visualize and grab the heart.

**Make friends and form alliances**:  Find elected champions, develop agency contacts, form alliances with a diverse set of groups.

**Make it happen**:  Use some or all of your advocacy tools – government relations, grassroots and media advocacy.

Jennifer Friedman, VP Government Affairs and Policy
National Rural Health Association

**RWHC**                                                                27

## Core Principles of Effective Advocacy

- Be **Brief**
- Be Accurate - **NEVER false** or misleading info
- **Personalize** Your Message - cite examples
- Be **Prepared** - know your issue
- Be Aware Every Issue Has **Two Sides** - there are voters on other side
- Be **Courteous**/Don't Threaten
- Be Patient - long process; be in for **long haul**

Wisconsin Hospital Association's Grass Roots Handbook

**RWHC**                                                                28

## Bottom Line: Follow Your Passion

**RWHC Eye On Health**



"Yes, I'm a generalist. I chose primary care over being a partialist."

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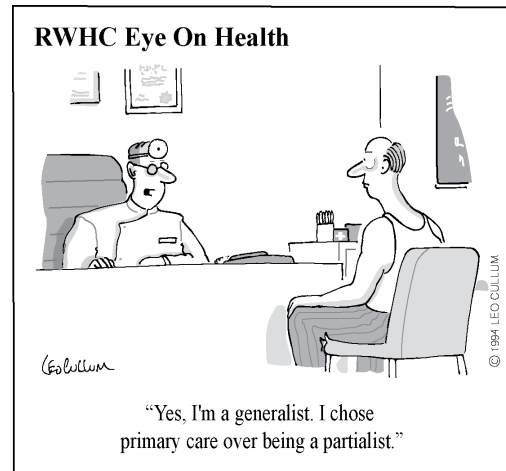
## Rural Health Resources

- **RWHC Web**: http://www.rwhc.com/
- **Wisconsin Office of Rural Health**: http://worh.org/
- For the free **RWHC Eye on Health e-newsletter**, email **office@rwhc.com** with "subscribe" on subject line.
- **Rural Assistance Center** at **www.raconline.org/** is an incredible federally supported information resource.
- The **Health Workforce Information Center** is RAC's new "sister" for health workforce programs, funding, data, research & policy **www.healthworkforceinfo.org/**
- **Wisconsin State Journal Special Report: Rural Health:** **http://host.madison.com/special-section/rural_health/**

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**Addendum: Advocacy Do's** (from WI Council on Children & Families)

- Form relationships! Don't wait until you need something
  to contact policy- makers.
- Be open to talking to legislative staff.
- Be informed! Know the issue, the system and the key players.
- Give personal examples! They are incredibly powerful.
- Be honest! Do not exaggerate. It's ok to admit that you don't know something and that you'll get back to the legislator with more information later.
- Be concise! Keep all visits, calls, testimonies brief and to the point.
- Practice, practice, practice! Explain your opinion & make your case to family, friends & colleagues before you make your case to policymakers.
- Seek out new partnerships & alliances with others who share your views.
- Be specific! Know what you want your legislator to do, and ask for it!
- Stay active! Maintain communication with policymakers.
- Be patient, persistent and positive.

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**Addendum: Advocacy Don'ts** (from WI Council on Children & Families)

- Wait until you need something to contact policymakers.
- Ignore or be disrespectful to legislative staff.
- Exaggerate.
- Send form letters or emails—lots and lots of 'em.
- Make threats.
- Expect the impossible or insist on immediate action.
- Pretend to speak for everyone.
- Bury them with paper.
- Don't argue—if it's clear the policymaker will not support your position, just give them the facts and ask him or her to consider your viewpoint. Keep the lines of communication open and think of ways to get other constituents to continue to talk to the legislator about that issue.
- **Don't give up!**

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# Advocacy Do's & Don'ts!

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**RWHC**
**Your partner. Your source.**

### Rural Education, Jobs & Health: Bound at the Hip
by Tim Size, Executive Director, Rural Wisconsin Health Cooperative, Sauk City

Each spring, the University of Wisconsin publishes a report: *County Health Rankings*, *Mobilizing Action Toward Community Health*. Part of the news continues to be not good. Rural people in Wisconsin continue to be less healthy and die sooner than their urban friends and relatives. Part of the news is good. Rural communities are taking action.

The UW report paints a stark contrast. Four of the five least healthy Wisconsin counties are rural. Four of the five healthiest counties are urban.

When I look at the healthiest counties I think of the guy who was born on third base and thought he hit a triple. But this is a story more like the first rule of real estate– it's location, location and location.

The main point of *County Health Rankings* is that the impact of a rural location on health is not fixed. There are rural counties that are among the healthiest and others that are actively working to improve their ranking. We can change what affects our health and make our communities and ourselves healthier.

Rural doctors and hospitals make a difference. But as hard as that work is, it is only part of the story. Social and economic issues like education, employment, income and our own behaviors like smoking, diet and alcohol are also major drivers of our health.



**RWHC Eye On Health**

"If no one lived around here, we could really save on the cost of health care and public education."

So what do we do? We need to commit to the idea that education, jobs and health are bound at the hip. We need to work for strong rural health and health care. We also must work to create jobs as well as support those working to educate our kids. These are not competing goals. You don't achieve one apart from the others.

What ever you do, the *County Health Rankings* website can help you work with others to mobilize your community. The Robert Wood Johnson Foundation supports a major online resource. (Google "county health rankings.") It is well worth your time to investigate the tools that are available.

Local school districts and Cooperative Educational Service Agencies throughout rural Wisconsin are getting involved. Students are learning the importance of healthier lifestyles.  Physical fitness and wellness topics are being brought into more classes. They are no longer confined to the gym and a single class on health "issues." Programs like the Farm to School are using local producers to improve the nutritional quality of school lunches.

The first job of employers is to grow their business. And hopefully also create local jobs. But they can also encourage employee fitness. They can educate all managers about the link between employee health and productivity. The *County Health Rankings* report makes clear that "a county's health affects its economic competiveness. Achieving lower health care costs, fewer sick days, and increased productivity are all critical to economic growth."

Economic development enterprises around the state are focusing on long-term, sustained results, aimed at building their region's competitive advantage. One such group, Thrive in southern Wisconsin, is also encouraging healthcare and business leaders to work together.  It believes healthier workplaces "drive down healthcare costs and increase employee engagement and productivity."

The *County Health Rankings* also helps health care professionals identify the underlying causes of health problems. "We can prevent many of the health problems seen every day in the clinics and hospitals. All of us have a role to play to improve the multiple factors that affect the health of our communities." All of us working in health care are uniquely positioned to partner with others to mobilize our communities to become healthier.

Barbara Theis, Juneau County's health officer, is a role model for many of us. "In 2006, Juneau County was the unhealthiest county in the state, but we turned it around, we challenged ourselves. We're moving forward, and we have committed stakeholders that are working together to make our county one of the healthiest." Rural Wisconsin needs more Juneau Counties.

![RWHC logo - Your partner. Your source.]

## Rural Health & Jobs Need Medicare's Ongoing Support

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative, Sauk City

One out of every six of us lives in rural America. The Midwest has the highest percentage of people living in rural communities (one out of every four).

Most of us have a job. Most of us have health insurance. Neither is perfect. You may feel you don't need to worry about what Congress does to Medicare. Guess again. Regardless of your age, it will affect you.

The politicians in Washington continue with their high stakes child's game of "king of the hill." As they do so, the fragile payment system supporting rural hospitals and clinics may be trampled.

Nearly a third of rural residents depend on public funding for their healthcare. This is typically the federal Medicare program for seniors or the federal and state Medicaid program for people with low income.

Our country's typical rural hospital or clinic is very dependent on Medicare funding. Seniors need and use health care at rates much higher than most. And there are more seniors in rural communities.

Apart from nursing homes, rural healthcare providers are much less dependent on Medicaid dollars as most Medicaid recipients are young and relatively healthy.

Medicaid typically pays much less than the cost of the services provided. If most rural hospitals or clinics depended mostly on Medicaid, they would be forced to close. The problem is that Medicare funding is quickly on the way to looking like Medicaid.



**RWHC Eye On Health**

"We could agree but then who would fund our re-election?"

Multiple rural Medicare programs that keep doors open and support local jobs are set to expire this October and December. In January, Congress is expected to implement across the board cuts to all hospitals and doctors through something they call "sequestration"–across the board cuts regardless of the level of need for the funds.

With these public funds slashed, rural hospitals and clinics won't close just for Medicaid patients. They won't close just for Medicare patients. They will close for the whole community.
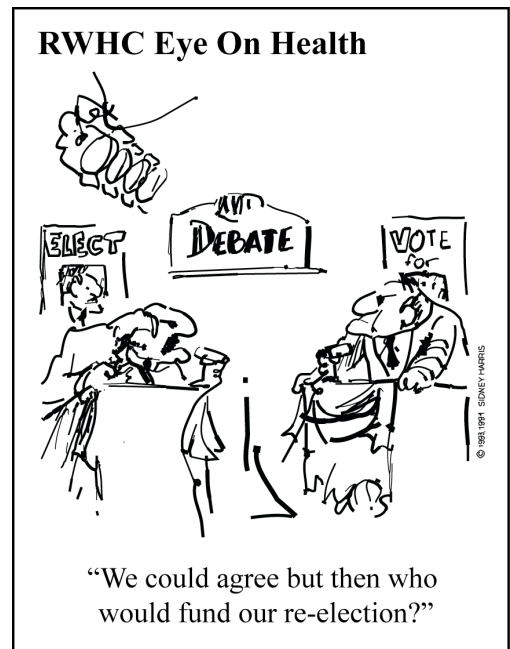
The National Rural Health Association just released a report that compares the effectiveness of rural and urban hospitals. (The comparison was done by iVantage Health Analytics, a private health care research company.) On most measures, rural hospitals compare quite favorably with their urban counterparts.  In fact, the study finds that, when matched against urban hospitals,  "rural hospitals have achieved a noteworthy level of comparative performance..." Rural health care is not more expensive than care in urban areas, and rural care is equal to, if not better, than care given in urban hospitals.

Now imagine losing your closest emergency room, hospital or clinic. Imagine the jobs and spending lost in the community. Congress must act to renew and protect Medicare programs that are the foundation of rural health care in America.

The Low-Volume Hospital program is one of the first programs set to expire. It was created by Congress to help rural hospitals who have a low number inpatient hospital stays. It helps to offset the higher costs of providing care to seniors. It assists hospitals providing care locally in lower volume settings.

Congress's own Medicare Payment Advisory Commission proposed the program in 2001. The adjustment operates on a sliding scale intended to target the hospitals that need it the most.

We know Washington is a mess. And I don't mean one party or the other. Congress is deadlocked. Most are more interested in bomb throwing than finding common ground. Few have the courage to pass any legislation in an election year. Few have the courage to not demonize their opponents.

There is a failure to focus on the large areas of common ground. The focus is on the fewer number of flash points that inspire radicals in both parties. It is paralyzing our country.

Access to rural health care is heavily dependent on a government that works. We need our representatives in Washington to start acting like adults if we are to retain rural health care in America.

![RWHC logo — Your partner. Your source.]

**What Rural Needs to Know About the *New* Medicare?**

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative, Sauk City

I love my digital video recorder, during election season more than ever. It is great to record favorite shows for watching whenever you want to. And it preserves my aging sanity to be able to click forward over the endless televised political tantrums.

Like many of us in Wisconsin, I'm tired of the endless candidate robocalls. Call me stupid, but I really don't think Republicans will send granny (my wife) over the cliff or that the Democrats will put her before a "death panel."

The real differences between the parties are significant. But both share the reality that Medicare is going broke and needs to be reformed. The question is how to do it?

"The Obama approach is to stay with government-provided traditional Medicare while putting pressure on health care providers to deliver care more efficiently, and instituting new payment models and coordination of care to cut costs. The Romney-Ryan plan turns to competition among insurance companies to lower costs and premium-support payments to induce seniors to pick their health plans based on price." (FactCheck.org, 8/22/12)



**RWHC Eye On Health**

"Not so sure I like the idea of being thrown under the bus to save granny from going off the cliff fleeing death panels."

This may be an election in which we get to pick our poison: health care run by big government or by big business. As an optimist, I believe Medicare over time will not stray too far from its American roots–taking care of our seniors while maintaining a healthy tension between the public sector and the marketplace.

But a lot of specifics are missing in action. I need to know what will the *new* Medicare do to rural Medicare beneficiaries, rural communities and the health care providers that serve them? For me, the following questions apply equally to both parties. **Will a *new* Medicare**…

… protect or undermine rural beneficiaries getting healthcare locally?

… make it harder for the rest of the rural community to receive care locally?

… encourage insurers and providers to serve all rural patients, including the least healthy?

… support the unique role of rural hospitals and clinics?

… increase or decrease the jobs available in rural America?
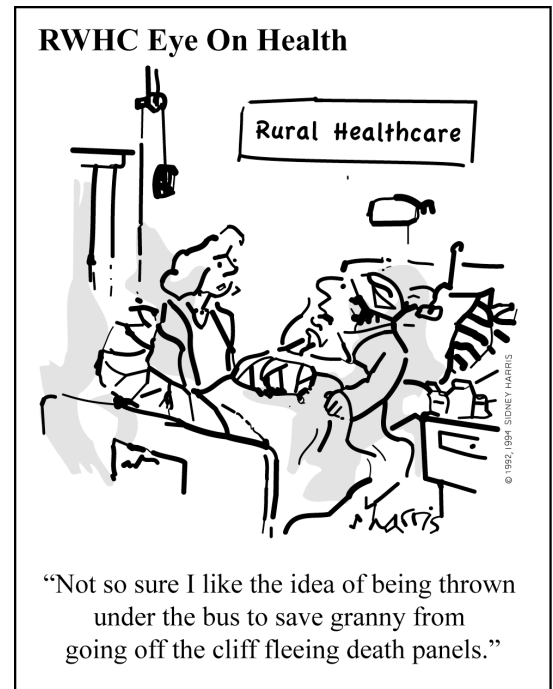
Like many of us who live and/or work in rural America, I am sick of being treated as if we are a drag on the Medicare program. Some would want you to believe that rural is a black hole for scarce Medicare dollars.

In fact, the opposite is true according to a new report by iVantage Health Analytics: "Physician services payments are 18% lower and Hospital service payments are 2% lower for Medicare beneficiaries living in rural versus non-rural settings. Cost per Medicare beneficiary is 3.7% lower overall for rural vs. urban beneficiaries."

"Approximately $7.2 billion in annual savings to the Medicare program could be realized if the average cost per urban beneficiary were equal to the average cost per rural beneficiary. Medicare already benefits from $2.2 billion of lower beneficiary costs for care delivered to rural beneficiaries vs. urban."

Rural citizens pay taxes at the same rate as all Americans. Some may wish to have rural pay more to receive less than the rest of the country. But there is no basis for saying that rural is receiving more than its fair share of Medicare spending.

Regardless of who wins this election, those of us in rural healthcare must be part of the solution. To be part of saving Medicare, Rural healthcare providers, like all providers, need to continue doing more, better for less.

We need to make the full transition to adopt health information technology. We need to focus on providing quality and cost effective care as opposed to simply the volume of service. We need to collaborate with each other and urban providers to deliver the continuum of care seamlessly to all patients. We need to partner with all parts of our rural communities to create a healthier people.

Bottom line: rural America is affected by where our health care dollars are spent; rural communities are hurt badly when policy and politics ignore the impact on rural health and the impact on the local rural economy.

**RWHC Vision, Mission, Key Strategies and Values**

*RWHC is owned and operated by thirty-seven, rural acute, general medical-surgical hospitals. The Cooperative's emphasis on developing a collaborative network among both freestanding and system affiliated rural hospitals distinguishes it from alternative approaches. In 1996, RWHC created a non-voting Affiliate Membership for specialty provider based systems.*

**Vision:** Rural Wisconsin communities will be the healthiest in America.

**Mission:** We are a strong and innovative cooperative of diversified rural hospitals.

**Key Strategies:** RWHC is the "rural advocate of choice" for its Members... it develops and manages a variety of programs and services... it assists Members to offer high quality, cost effective healthcare… assists Members to partner with others to make their communities healthier… and actively uses strategic alliances in pursuit of its Vision.

**Core Values**:

TRUST–We rely on each other; mutual trust assumes the potential performance and visions not yet fully formed in written agreements. We assume positive intent first when things go wrong. We are honest and forthright in meeting our commitments.

COLLABORATION–Within an organization or network, people working together creates better value than competition; our relationships are based on mutual respect and a sense of shared purpose. We strive to be a national leader in rural health collaboration.

CREATIVITY–Complex challenges benefit from the innovation that comes from new ideas or new links among existing ideas.

EXCELLENCE–We always strive to do high quality work; what we all do matters; others will receive from us high quality performance.

PRIDE–We take pride in the work we do knowing it is supporting the healing mission of many.

OPENNESS–Information is shared and affected parties are involved.

INDIVIDUAL DEVELOPMENT–Our most important resource is each other and we do our best work when we continue to invest in life long learning and development, both professionally and/or personally.

PRODUCTIVITY–We maximize our achievement and we work to acquire the level of resources needed to do so.

RESPONSIBILITY–Each of us has a clear understanding of what is expected of us; everyone's job is important to RWHC. Each of us has an individual obligation, not diminished by being part of a team, to perform at his or her highest possible level.

# RWHC Overview
as of 1/14/13

Incorporated in 1979 as the Rural Wisconsin Hospital Cooperative, RWHC has received national recognition as one of the country's earliest and most successful models for networking among rural hospitals. Today, the work continues as the renamed Rural Wisconsin *Health* Cooperative responds to the needs of its diverse members and their communities.

RWHC serves as a catalyst for statewide collaboration and a progressive, creative force on behalf of all rural health constituencies. Owned by 37 non-profit rural acute, general medical-surgical hospitals, RWHCs charge is twofold: advocacy for rural health at the State and Federal levels, and shared service development for member hospitals as well as external customers. The Core Values of *trust, collaboration, creativity, excellence, pride, openness, individual development, productivity, and responsibility* continue to define the work of RWHC and its members.

RWHC's advocacy agenda is as follows:

1.  Federal **healthcare reform** that recognizes rural realities.
2.  Fair **Medicare and Medicaid** payments to rural providers.
3.  **Federal and State regulations** that recognize rural realities.
4.  **Retain property tax exemption** for nonprofit hospitals.
5.  Solve growing **shortage of rural physicians and providers**.
6.  Bring rural voice to **regional provider networks and payers**.
7.  Bring a rural voice into the **quality improvement** movement.
8.  Continue push for workplace and community **wellness**.
9.  Strong link between **economic development** and rural health.

The tenants of advocacy and shared service have benefited one another over the years. Since its inception, RWHC has maintained a philosophy of "together, we are better", working collaboratively to represent the smaller rural hospital arena as an important stakeholder at the policymaker's table. Initiatives from CAH Status development through Rural HIT have benefited from RWHC's expertise in crafting rural health policy. Today, that expertise continues to shape the landscape of rural health services in America.

Shared services have grown through collaborative efforts and continue to provide sustainable alternatives to our rural partners both in Wisconsin and around the country. At the heart of RWHC service line development is the commitment to be an *affordable and effective option* for rural health organizations in the areas of *quality, patient satisfaction, credentialing, HIT, workforce development, financial consulting, and reporting compliance with regulatory agencies*. RWHC's business model gives us the opportunity to deliver services that are innovative and reliable, yet affordable for the

smaller hospital. With more than 30 years of experience, RWHC continues to be recognized as a leader providing shared services to smaller hospitals.

Continued growth has lead to RWHC establishing three additional stand alone business entities. First, the RWHC Network was established to negotiate HMO and other insurer contracts. The Network assists members with payer contract development and management. The RWHC PHO was founded to work with hospitals and physicians on issues surrounding Medicare Advantage programs. And finally, in 2007 RWHC and Member hospitals founded the RWHC Information Technology Network, a 501(c) 3 organization delivering shared EHR and HIT services.

# Rural Wisconsin Health Cooperative: Milestones 1979-2012

*By definition, lists are incomplete; below is a sample of important milestones.*

**1979**  The Rural Wisconsin Hospital Cooperative (RWHC) was incorporated on June 26th as a shared service organization by six hospital administrators: Ken Creswick (Cuba City), Earl Strub (Lancaster), Bill Beach (Prairie du Sac), Gary Deml (Dodgeville), Dave Shipley (Boscobel) and Tim Size (University of Wisconsin Hospital & Clinics, Madison).

Advocacy was added to the RWHC mission in response to a proposal from the Madison centric and federally funded Southern Wisconsin Health Planning Council. The HPC recommended (after a series of closed meetings with only one "rural" participant) that most rural hospitals in southern Wisconsin either close or merge.

**1980**  On January 1st, RWHC opened a one-room office over the boiler room in the annex of Memorial Hospital of Iowa County with Tim Size as the Executive Director.

RWHC's first shared service, Physical Therapy, was initiated by Dennis O'Connell.

**1983**  RWHC applied for and received its first grant, "Cooperative Infection Control" from the W.K. Kellogg Foundation in collaboration with Dr. Bill Scheckler, hospital epidemiologist at St. Mary's Hospital in Madison.

HMO of Wisconsin (now operating as Unity Health Plans) was developed by RWHC, again with key support from St. Mary's Hospital in Madison.

**1984**  RWHC first became active nationally as a vocal advocate for Medicare payment equity when its executive director was invited to speak in Washington, DC, on behalf of rural hospitals at a Georgetown University Health Policy Institute Roundtable focusing on the first year of the Prospective Payment System.

Mobile CT and Nuclear Medicine services were initiated through the development of private sector partnerships.

**1985**  RWHC was recognized with a "Citation of Merit" by the Wisconsin Legislature and given the "Outstanding Rural Health Program Award" by the National Rural Health Association.

Initiated a Health Benefits Program as a mechanism for RWHC members who self-fund their employees health insurance to pool their cash for claims payments and to gain the benefit of group purchasing for their claims administration and reinsurance. (The pro-

gram was terminated 7 years later due to changes in the applicable federal law as well as adverse risk selection.)

**1987**  The Wisconsin Hospital Association gave RWHC its annual Award of Merit.

**1988**  RWHC, through the National Rural Health Association, triggered the fundraising and filing of a class-action suit against the Department of Health and Human Services for an "unjust taking of property" due to a failure to provide just compensation to rural hospitals for services to Medicare patients.

A three year grant award was received from Robert Wood Johnson Foundation to participate in their Hospital-Based Rural Health Care Program. A key legacy from this Program was the eventual development of over three dozen RWHC Roundtables–structured peer to peer networking representing a wide range of clinical and non-clinical disciplines.

RWHC's executive director was appointed by then Governor Tommy Thompson to the Wisconsin Health & Education Facilities Authority in order to encourage a more proactive approach with rural hospitals (His most recent reappointment goes through June, 2018).

RWHC's executive director testified before the U.S. Senate Special Committee on Aging.

**1989**  A three year grant award was received from the Robert Wood Johnson Foundation and the Pew Charitable Trusts for "Strengthening Hospital Nursing."

RWHC's executive director testified before the U.S. Joint Economic Committee and the Senate Finance Committee.

**1990**  RWHC played a significant role in the Legislature when it authorized the Wisconsin's Rural Health Development Council.

**1992**  A three year grant award was received for "Rural Occupational Health" from the Federal Health Outreach Program, Health Resources & Service Administration.

**1993**  RWHC established the Hermes Monato Annual Rural Health Essay Prize, in memory of a employee; in 2011 the prize is $2,500 from a fund held by the University of Wisconsin.

**1994**  HMO of Wisconsin was sold by its rural owners to United Wisconsin services (a Blue-Cross subsidiary) and subsequently merged with an U-Care HMO based at the University of Wisconsin. A joint venture among these entities governed the resulting HMO, Unity Health Plans. Community Health System LLC was created to represent the prior rural provider/owners of HMO of Wisconsin and RWHC was chosen to administer the LLC.

**1995**  Name changed to Rural Wisconsin Health Cooperative to better reflect RWHC's increasingly broader mission as well as the diverse services offered by its members.

Initiated the "Eye on Health" newsletter and **www.RWHC.com** website.

**1996** Received initial approval of a business advisory letter from the U.S. Department of Justice allowing RWHC to develop RWHC Network as a related entity to work with health insurers.

**1997** Received a federal "Network Grant" to increase the effectiveness and utilization of its regional credentialing service as well as implement a model for providers, plans and direct purchasers to collaborate on quality data collection and customer satisfaction surveys.

A three year grant award was received from the federal Health Resources and Services Administration for "The Wisconsin Rural Zones of Collaboration Initiative."

RWHC's executive director served as President of the National Rural Health Association, as have two others from RWHC (Harold Brown and Bill Sexton) and Fred Moskol (the director of the Wisconsin Office of Rural Health for its first quarter century.)

**1998** RWHC became a Joint Commission certified OryX Vendor.

Established a non-voting Affiliate Membership to enhance its relationships with regional, tertiary based, provider systems.

**1999** RWHC, along with the Wisconsin Department of Health & Family Services, the Wisconsin Hospital Association and the state Office of Rural Health wrote the Wisconsin Rural Health Plan, assuring that the "necessary provider" designation criteria to become a Critical Access Hospital reflected Wisconsin values.

RWHC first achieves NCQA Certification as a Credentials Verification Organization.

Successfully renegotiated a second five year joint venture to govern Unity Health Plans along with United Wisconsin Services and the University of Wisconsin.

RWHC's executive director was appointed by the Governor to represent hospitals on the Employer Health Care Coverage Board and was subsequently elected to Chair the Board.

Following the departure of RWHC's long serving deputy director, Pat Ruff, the leadership structure was restructured into a senior staff team.

**2000** RWHC administered a federal Outreach grant on behalf of three county health departments and five rural hospitals to address the health promotion and disease and injury prevention needs of the farmers and agricultural laborers.

After twenty years in five different rental properties, RWHC built its own 9,100 sq ft building in the Sauk City Business Park.

A Premier Coding Consultation Service was initiated.

The RWHC Award of Excellence in Nursing Clinical Practice was launched.

In partnership with Albert Lanier and Ron Shaffer at the Center for Community Economic Development, University of Wisconsin-Extension, published the study "The Economic Value of the Health Care Industry In Sauk County, Wisconsin"

**2001**   Developed alternative sources of blood products for rural hospitals in response to a series of unilateral changes by the then only regional source.

       The RWHC Award of Excellence in Nursing Management was launched.

**2002**   RWHC implemented a shared data network that allowed for secure T1 connections between the member hospitals and a central data center.

       National Rural Health Association gave its top honor, the Louis Gorin Award for Outstanding Achievement, to RWHC's executive director.

**2003**   The Wisconsin Nurse Residency Program was initiated at RWHC in partnership with Marquette University.

       With the Wisconsin Office of Rural Health, RWHC initiated a health careers website with a focus on rural health opportunities, **www.RHCW.org** (Rural Health Careers Wisconsin).

       Received a research grant to address "How Can Rural Balanced Scorecards Best Incorporate Population Health Measures?" from the University of Wisconsin Health & Society Research Competition, funded by Robert Wood Johnson Foundation.

       RWHC's executive director appointed to a rare repeat term on the National Advisory Committee on Rural Health & Human Services for the U.S. Department Health & Human Services.

       RWHC's executive director briefed U.S. Senate Rural Health Caucus and House Rural Health Coalition.

**2004**   RWHC facilitated the rural owners of HMO of Wisconsin to exercise their right to buy back HMO of Wisconsin and then sell the company to University Health Care.

       The Agency for Healthcare Research & Quality awarded RWHC a Transforming Healthcare Quality Through Health Information Technology one-year planning grant.

       RWHC received a planning grant on behalf of a statewide collaborative for the "Wisconsin Academy of Rural Medicine," a medical school within a medical school, from the Wisconsin Partnership Fund for a Healthy Future.

       The RWHC Rural Health Ambassadors recognition program was launched.

**2005** RWHC hired a director of health information technology and began organizing a shared electronic health record (EHR) taskforce.

Received a research grant for "What Policies Encourage Local Collaboration for Population Health in Rural Communities?" from the University of Wisconsin Health & Society Research Competition, funded by Robert Wood Johnson Foundation.

**2006** RWHC, LLC was formed by the RWHC Network to operate as a PHO on behalf of participating members in contracting with Medicare Advantage (MA) plans.

RWHC became a certified HCAHPS Vendor.

Developed with members, Club Scrub was an interactive health careers program targeting middle school students.

Beginning of transition to the RWHC Office & Training Center with the purchase of Mediasite technology and other state of the art communication for long distance networking.

RWHC's submitted an affidavit to defend the work of nurse anesthetists before the Wisconsin Medical Examining Board.

Inauguration of the Hospital to Hospital Program (H2H)–a structured process for member CEOs to routinely seek out and visit other hospitals in order to gain additional insights to enhance their organization's performance.

RWHC, in collaboration with others, raised nearly a million dollars to support the Strong Rural Communities Initiative (SRCI)–a statewide collaboration among medical, business and public health sectors. (This was the first community based initiative to receive support from both of Wisconsin "BlueCross Conversion Foundations.")

**2007** RWHC Information Technology Network incorporated as a 501(c)3 organization dedicated to providing member hospitals with shared HIS/EHR services. Four RWHC facilities signed on as founding members. Helping to support the initiative, three grants were awarded to RWHC: (1) Health Resources and Services Administration's (HRSA) CAHHIT Network grant for $1.6 million; (2) Federal Communications Commission's Rural Healthcare Pilot Program for up to $1.5 million; and (3) a federal appropriation through Senator Herb Kohl's office for $181,000.

RWHC Nurse Residency Program was highlighted in the December issue of *Hospital & Health Networks*–the retention statistics for the first and second years of the program were 89 percent and 87 percent of the 31 nurses in the program were retained.

RWHC hosts a two day "field visit" for the National Advisory Committee on Rural Health & Human Services.

A Corporate Sponsors program was initiated to formalize relationships with multiple companies/vendors/consultants that provide discounted services to member hospitals.

**2008**    RWHC hired its first full-time director of advocacy and the executive director was listed on *Modern Healthcare's* "100 Most Powerful People in Healthcare."

RWHC started contributing substantial "loaned executive time" to the Wisconsin Health Workforce Data Collaborative (WHWDC).

RWHC ITN became the first network in the country to implement telecommunications services as part of the FCC Rural Healthcare Pilot Program.

RWHC launched a well-received leadership series (primarily workshops and coaching sessions) focusing on core leadership behaviors, long-term goal/strategy development, performance management, talent management, culture surveys, and a 360-degree evaluation tool.

**2009**    Received from the National Cooperative of Health Networks Association its first "Annual Outstanding Health Network of the Year."

The Wisconsin Office of Rural Health partnered with RWHC's Director of Health Information Technology to develop an informational blog, *Rural Health IT*.

On behalf of the WHWDC, a three year Impact grant was successfully pursued for the "Collaborative Response to the Growing Wisconsin Health Workforce Crisis" from the Healthier Wisconsin Partnership Program at the Medical College.

**2010**    *Leadership Insights* monthly newsletter and the *Rural Health Advocate* blog were launched.

Received subcontract through WHITEC to provide meaningful use technical assistance to rural Wisconsin hospitals through the ARRA funded Regional Extension Center program.

Received an equipment training grant from HRSA to purchase computerized patient simulators to assist with training rural nurses.

**2011**    RWHC Proposed the Wisconsin Rural Training Track Collaborative to the Wisconsin Rural Physician Residency Assistance Program for start up funding.

RWHC filed amicus briefs in two separate cases challenging hospital property tax exemptions; the first was successful and the second is pending (as of 12/21/11).

Launched the Southern Wisconsin Immunization Coalition with generous support from Dean Healthcare, Unity Healthcare, the University of Wisconsin Partnership Program and the Wisconsin Office of Rural Health.

A "Mystery Shopper" Program (using phone and on site visits by and at all participating hospitals) was implemented with 11 members participating in the first round.

The Wisconsin Center for Nursing assisted by RWHC are designated by the Robert Wood Johnson Foundation and AARP as co-leads of the Future of Nursing: Campaign for Action in Wisconsin.

RWHC QI Program becomes one of the first modular EHR vendors to achieve meaningful use for clinical quality measures.

The Wipfli-RWHC Cost Champions Award was initiated.

The Wisconsin Partnership Program awarded a Development Grant of $50,000 to RWHC for "Related Lower Extremity Injury Prevention in Rural High Schools."

A 4,200 sq ft expansion to the Office & Training Center is completed.

2012    Beaver Dam Community Hospitals, St. Croix Regional Medical Center, and Cumberland Healthcare become the three newest voting members of RWHC.

Hospital Sisters Health System becomes the newest affiliate member of RWHC.

RWHC launched the Document Assessment Service. This service assesses compliance with Conditions of Participation and Medicare manuals, core measure populations, accurate coding functions, and provides physician peer review. This approach includes a comprehensive review of documentation protocols and communicates inclusive recommendations to overcome documentation hurdles that will improve reimbursement.

RWHC receives a Distance Learning Grant from the USDA to expand the scope and efficiency of virtual meeting and educational offerings. The matching grant funds were used to improve teleconference, web-enabled video, and expand inter-connectivity between remote participants of RWHC programs.

The Wisconsin Collaborative for Rural Graduate Medical Education, WCRGME (formerly known as the Wisconsin Rural Training Track Collaborative, WRTTC) held its first formal meeting in February. Two new staff, the Development & Support Manager and the Rural Graduate Education Assistant, were hired to assist with the administration and accreditation of rural GME programs.

RWHC's Executive Director receives the President's Award at the NRHA's Annual Conference in Denver, CO.

A "Lean Lab" led by Paul Frigoli, Ph.D. (c), Lean Six Sigma Master Black Belt, QI Director/Risk Manager at Grant Regional Health Center in Lancaster, WI, was developed and started in September. Consisting of six "lab" meetings, this workshop pro-

vides an excellent opportunity for participants to learn the basic Lean concepts and apply them to a facility specific project.

The RWHC Leadership Series offers the first regional outreach program, through a partnership with The National Rural Health Resource Center and the NE Minnesota AHEC in Duluth, MN. This four part series supported the work of more than 100 healthcare professionals in northwest Wisconsin and northeast Minnesota.

RWHC has grown to 37 member hospitals and 68 employees (54 FTE). Our work is supported by 8 affiliate members, 4 strategic partners, 4 corporate partners, and 10 corporate sponsors.

**Membership Application Process**

While the emphasis of RWHC is to better serve existing members, new members are welcomed. The application process is informal–the Board engages in discussion to see if new membership will result in a mutually beneficial relationship.

**For Additional Information**

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Last Updated: 2/25/13

# Top Rural Hospital Websites
by Tim Size, 1/18/13


**WISCONSIN**

**Rural Health Careers Wisconsin**
www.rhcw.org

**Rural Wisconsin Health Cooperative (RWHC)**
www.RWHC.com

**University of Wisconsin Population Health Institute**
http://uwphi.pophealth.wisc.edu

**Wisconsin Academy of Rural Medicine**
www.med.wisc.edu/education/md/warm/wisconsin-academy-for-rural-medicine/187

**Wisconsin Department of Health Services**
www.dhs.wisconsin.gov

**Wisconsin Community Health Improvement Process & Plans (CHIPPs)**
www.dhs.wisconsin.gov/CHIP/

**Wisconsin Hospital Association (WHA)**
www.wha.org

**Wisconsin Medical Society**
www.wisconsinmedicalsociety.org

**Wisconsin Office of Rural Health**
www.worh.org


**NATIONAL**

**American Hospital Association (AHA)**
www.aha.org/

**American Hospital Association– Section for Small or Rural Hospitals**
www.aha.org/about/membership/constituency/smallrural/index.shtml

**Association for Community Health Improvement**
www.communityhlth.org

**County Health Rankings & Roadmaps**
www.countyhealthrankings.org

**Daily Yonder–Keep it Rural**
www.dailyyonder.com

**Health Workforce Information Center**
www.hwic.org

**Hospital Compare**
www.medicare.gov/hospitalcompare/

**Medicare Rural Hospital Flexibility**
www.hrsa.gov/ruralhealth/about/hospitalstate/medicareflexibility_.html

**National Organization of State Offices of Rural Health (NOSORH)**
www.nosorh.org

**National Rural Health Association**
www.ruralhealthweb.org

**National Rural Health Resource Center**
www.ruralcenter.org

**Rural Assistance Center**
www.raconline.org

**3RNet-Rural Healthcare Jobs Across the Nation**
www.3rnet.org

# Glossary of Hospital & Health Care Terms

*From "AHA Data" from the Health Forum at* **www.ahadataviewer.com/glossary/** *on 1/2/12*

**A**

**Acute long term care**—Provides specialized acute hospital care to medically complex patients who are critically ill, have multisystem complications and/or failure, and require hospitalization averaging 25 days, in a facility offering specialized treatment programs and therapeutic intervention on a 24 hour/7 day a week basis.

**Adjusted admissions**—An aggregate figure reflecting the number patients admitted during the reporting period, plus an estimate of the volume of outpatient services, expressed in units equivalent to an (admission) inpatient day in terms of level of effort. The figure is derived by first multiplying the number of outpatient visits by the ratio of outpatient revenue per outpatient visit to inpatient revenue per inpatient day. The product (which represents the number of admissions attributable to outpatient services) is then added to the number of admissions. Originally, the purpose of this calculation was to summarize overall productivity and calculate a unit cost that would include both inpatient and outpatient admissions.

**Adjusted average daily census**—An estimate of the average number of patients (both inpatients and outpatients) receiving care each day during the reporting period, which is usually 12 months. The figure is derived by dividing the number of inpatient day equivalents (also called adjusted inpatient days) by the number of days in the reporting period.

**Adjusted patient days**—An aggregate figure reflecting the number of days of inpatient care, plus an estimate of the volume of outpatient services, expressed in units equivalent to an inpatient day in terms of level of effort. The figure is derived by first multiplying the number of outpatient visits by the ratio of outpatient revenue per outpatient visit to inpatient revenue per inpatient day. The product (which represents the number of patient days attributable to outpatient services) is then added to the number of inpatient days. Originally, the purpose of this calculation was to summarize overall productivity and calculate a unit cost that would include both inpatient and outpatient activities.

**Admissions**—The number of patients, excluding newborns, accepted for inpatient service during the reporting period; the number includes patients who visit the emergency room and are later admitted for inpatient service.

**Adult cardiac electrophysiology**—Evaluation and management of patients with complex rhythm or conduction abnormalities, including diagnostic testing, treatment of arrhythmias by catheter ablation or drug therapy, and pacemaker/defibrillator implantation and follow-up.

**Adult cardiac surgery**—Includes minimally invasive procedures that include surgery done with only a small incision or no incision at all, such as through a laparoscope or an endoscope and more invasive major surgical procedures that include open chest and open heart surgery.

**Adult cardiology services**—Includes minimally invasive procedures that include surgery done with only a small incision or no incision at all, such as through a laparoscope or an endoscope and more invasive major surgical procedures that include open chest and open heart surgery.

**Adult day care program**—Program providing supervision, medical and psychological care, and social activities for older adults who live at home or in another family setting, but cannot be alone or prefer to be with others during the day. May include intake assessment, health monitoring, occupational therapy, personal care, noon meal, and transportation services.

**Adult diagnostic catheterization**—Cardiac angiography, also called coronary angiography or coronary arteriography, is used to assist in diagnosing complex heart conditions. It involves the insertion of a tiny catheter into the artery in the groin then carefully threading the catheter up into the aorta where the coronary arteries originate. Once the catheter is in place, a dye is injected which allows the cardiologist to see the size, shape, and distribution of the coronary arteries. Images are used to diagnose heart disease and to determine, whether or not surgery is indicated.

**Adult interventional cardiac catheterization**—Non surgical procedure that utilizes the same basic principles as diagnostic catheterization and then uses advanced techniques to improve the heart's function. It can be a less-invasive alternative to heart surgery.

**AHA ID**—AHA Assigned unique identification number

**Airborne infection isolation room**—A single-occupancy room for patient care where environmental factors are controlled in an effort to minimize the transmission of those infectious agents, usually spread person to person by droplet nuclei associated with coughing or inhalation. Such rooms typically have specific ventilation requirements for controlled ventilation, air pressure and filtration.

**Alcohol/drug abuse or dependency inpatient care**—Provides diagnosis and therapeutic services to patients with alcoholism or other drug dependencies. Includes care for inpatient/residential treatment for patients whose course of treatment involves more intensive care than provided in an outpatient setting or where patient requires supervised withdrawal.

**Alcohol/drug abuse or dependency inpatient care beds**—Staffed beds set up for patient care in a dedicated alcohol/drug abuse or dependency care unit.

**Alcohol/drug abuse or dependency outpatient services**—Organized hospital services that provide medical care and/or rehabilitative treatment services to outpatients for whom the primary diagnosis is alcoholism or other chemical dependency.

**Alzheimer Center**—Facility that offers care to persons with Alzheimer's disease and their families through an integrated program of clinical services, research, and education.

**Ambulance services**—Provision of ambulance services to the ill and injured who require medical attention on a scheduled or unscheduled basis.

**Ambulatory surgery center**—Facility that provides care to patients requiring surgery who are admitted and discharged on the same day. Ambulatory surgery centers are distinct from same day surgical units within the hospital outpatient departments for purposes of Medicare payments.

**Arthritis treatment center**—Specifically equipped and staffed center for the diagnosis and treatment of arthritis and other joint disorders.

**Assisted living services**—A special combination of housing, supportive services, personalized assistance and health care designed to individual needs of those who need help in activities of daily living and instrumental activities of daily living. Supportive services are available, 24 hours a day, to meet scheduled and unscheduled needs, in a way that promotes maximum independence and dignity for each resident and encourages the involvement of a resident's family, neighbor and friends.

**Assistive technology center**—A program providing access to specialized hardware and software with adaptations allowing individuals greater independence with mobility, dexterity, or increased communication options.

**Auxiliary**—A volunteer community organization formed to assist the hospital in carrying out its purpose and to serve as a link between the institution and the community.

**Average daily census**—The average number of people served on an inpatient basis on a single day during the reporting period; the figure is calculated by dividing the number of inpatient days by the number of days in the reporting period.

# B

**Bariatric/weight control services**—Bariatrics is the medical practice of weight reduction.

**Bassinets set up and staffed**—Beds for babies, either normal newborns or those receiving special care in a neonatal intensive or intermediate care unit. Bassinets for normal newborns are not counted as inpatient beds, but as a separate count. Bassinets in neonatal intensive and intermediate care units are counted as part of the hospital's overall staffed and/or licensed bed count.

**Bed size code**—Indicates which of eight (8) pre-defined bed size ranges the hospital fits. Bed size ranges are: 6-24, 25-49, 50-99, 100-199, 200-299, 300-399, 400-499, 500+

**Beds (total facility)**—Number of beds regularly maintained (set up and staffed for use) for inpatients as of the close of the reporting period. Excludes newborn bassinets.

**Birthing room/LDR room/LDRP room**—A single-room type of maternity care with a more homelike setting for families than the traditional three-room unit (labor/delivery/recovery) with a separate postpartum area. 1 = Yes; 0 = No. A birthing room combines labor and delivery in one room. An LDR room accommodates three stages in the birthing process-- labor, delivery, and recovery. An LDRP room accommodates all four stages of the birth process--labor, delivery, recovery, and postpartum.

**Blood Donor Center Hospital**—A facility that performs, or is responsible for the collection, processing, testing or distribution of blood and components.

**Bone Marrow transplant services**—The branch of medicine that transfers healthy bone marrow from one person to another or from one part to another to replace a diseased structure or to restore function or to change appearance.

**Breast cancer screening/mammograms**—Provides mammography screening, the use of breast x-ray to detect unsuspected breast cancer in asymptomatic women and/or diagnostic mammography, the x-ray imaging of breast tissue in symptomatic women who are considered to have a substantial likelihood of having breast cancer already.

**Burn care**—Provides care to severely burned patients, which include any of the following: (1) second-degree burns of more than 25% total body surface area for adults or 20% total body surface area for children: (2) third-degree burns of more than 10% total body surface area; (3) any severe burns of the hands, face, eyes, ears, or feet; or (4) all inhalation injuries, electrical burns, complicated burn injuries involving fractures and other major traumas, and all other poor risk factors.

**C**

**Cardiac intensive care**—Provides patient care of a more specialized nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open-heart surgery, or other life-threatening conditions, require intensified, comprehensive observation and care. May include myocardial infarction, pulmonary care, and heart transplant units.

**Cardiac Rehabilitation**—A medically supervised program to help heart patients recover quickly and improve their overall physical and mental functioning. The goal is to reduce risk of another cardiac event or to keep an already present heart condition from getting worse. Cardiac rehabilitation programs include: counseling to patients, an exercise program, helping patients modify risk factors such as smoking and high blood pressure, providing vocational guidance to enable the patient to return to work, supplying information on physical limitations and lending emotional support.

**Case Management**—A system of assessment, treatment planning, referral and follow-up that ensures the provision of comprehensive and continuous services and the coordination of payment and reimbursement for care.

**Census Region**—AHA Region Code

**Chaplaincy/pastoral care services**—A service ministering religious activities and providing pastoral counseling to patients, their families, and staff of a health care organization.

**Chemotherapy**—An organized program for the treatment of cancer by the use of drugs or chemicals

**Children's wellness program**—A program that encourages improved health status and a healthful lifestyle of children through health education, exercise, nutrition and health promotion.

**Chiropractic services**—An organized clinical service including spinal manipulation or adjustment and related diagnostic and therapeutic services.

**Community Health Education**—Education that provides information to individuals and populations, support to personal, family and community health decisions with the objective of improving health status.

**Community hospital designation**—Community hospitals are designated as all nonfederal, short-term general, and special hospitals, including special children's hospitals, whose facilities and services are available to the public.

**Community outreach**—A program that systematically interacts with the community to identify those in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter the service delivery system.

**Complementary and alternative medicine services**—Organized hospital services or formal arrangements to providers that provide care or treatment not based solely on traditional western allopathic medical teachings as instructed in most U.S. medical schools. Includes any of the following: acupuncture, chiropractic, homeopathy, osteopathy, diet and lifestyle changes, herbal medicine, massage therapy, etc.

**Computer assisted orthopedic surgery**—Orthopedic surgery using computer technology, enabling three-dimensional graphic models to visualize a patient's anatomy.

**Contract managed hospital**—Indicates whether hospital is contract managed. General day-to-day management of an entire organization by another organization under a formal contract. Managing organization reports directly to the board of trustees or owners of the managed organization; managed organization retains total legal responsibility and ownership of the facility's assets and liabilities.

**Control/Ownership Type**—The type of organization responsible for establishing policy concerning the overall operation of hospitals.

**Crisis prevention**—Services provided in order to promote physical and mental well being and the early identification of disease and ill health prior to the onset and recognition of symptoms so as to permit early treatment.

**Critical Access Hospital**—Geographically isolated hospitals with no more than 25 inpatient beds that provide 24-hour emergency care and receive cost-based reimbursement for inpatient and outpatient services.

**D**

**Dental services**—An organized dental service or dentists on staff, not necessarily involving special facilities, providing dental or oral services to inpatients or outpatients.

**Diagnostic radioisotope facility**—The use of radioactive isotopes (radiopharmaceuticals) as tracers or indicators to detect an abnormal condition or disease.

**E**

**Electrodiagnostic services**—Diagnostic testing services for nerve and muscle function including services such as nerve conduction studies and needle electromyography.

**Electron Beam Computed Tomography (EBCT)**—A high tech computed tomography scan used to detect coronary artery disease by measuring coronary calcifications. This imaging procedure uses electron beams which are magnetically steered to produce a visual of the coronary artery and the images are produced faster than conventional CT scans.

**Emergency Department**—Hospital facilities for the provision of unscheduled outpatient services to patients whose conditions require immediate care.

**Emergency room visits**—Number of emergency room visits reported by the hospital. An emergency room visit is defined as a visit to the emergency unit. When an emergency outpatient is admitted to the inpatient area of the hospital, he or she is counted as an emergency room visit and subsequently, as an inpatient admission.

**Enabling Services**—A program that is designed to help the patient access health care services by offering any of the following linguistic services, transportation services, and/or referrals to local social services agencies.

**Endoscopic retrograde cholangiopancreatography (ERCP)**—A procedure in which a catheter is introduced through an endoscope into the bile ducts and pancreatic ducts. Injection of contrast material permits detailed x-ray of these structures. The procedure is used diagnostically as well as therapeutically to relieve obstruction or remove stones.

**Endoscopic ultrasound**—Specially designed endoscope that incorporates an ultrasound transducer used to obtain detailed images of organs in the chest and abdomen. The endoscope can be passed through the mouth or the anus. When combined with needle biopsy the procedure can assist in diagnosis of disease and staging of cancer.

**Enrollment Assistance Program**—A program that provides enrollment assistance for patients who are potentially eligible for public health insurance programs such as Medicaid, State Children's Health Insurance, or local/state indigent care programs.

**Esophageal impedance study**—A test in which a catheter is placed through the nose into the esophagus to measure whether gas or liquids are passing from the stomach into the esophagus and causing symptoms.

**Extracorporeal shock waved lithotripter (ESWL)**—A medical device used for treating stones in the kidney or urethra. The device disintegrates kidney stones noninvasively through the transmission of acoustic shock waves directed at the stones.

**F**

**Fertility Clinic**—A specialized program set in an infertility center that provides counseling and education as well as advanced reproductive techniques such as: injectable therapy, reproductive surgeries, treatment for endometriosis, male factor infertility, tubal reversals, in vitro fertilization (IVF), donor eggs, and other such services to help patients achieve successful pregnancies.

**Fitness center**—Provides exercise, testing, or evaluation programs and fitness activities to the community and hospital employees.

**Freestanding/Satellite Emergency Department**—A facility owned and operated by the hospital but physically separate from the hospital for the provision of unscheduled outpatient services to patients whose conditions require immediate care.

**Full-field digital mammography**—Combines the x-ray generators and tubes used in analog screen-film mammography (SFM) with a detector plate that converts the x-rays into a digital signal.

**G**

**Gen. medical/surgical adult care**—Provides acute care to patients in medical and surgical units on the basis of physicians' orders and approved nursing care plans.

**Gen. medical/surgical pediatric care**—Provides acute care to pediatric patients on the basis of physicians' orders and approved nursing care plans.

**Geriatric services**—The branch of medicine dealing with the physiology of aging and the diagnosis and treatment of disease affecting the aged. Services could include: adult day care; Alzheimer's diagnostic-assessment services; comprehensive geriatric assessment; emergency response system; geriatric acute care unit; and/or geriatric clinics.

**GPO**—A Group Purchasing Organization negotiates purchasing contracts for members of the group or has a central supply site for its members.

**H**

**Health Fair**—Community health education events that focus on the prevention of disease and promotion of health through such activities as audiovisual exhibits and free diagnostic services.

**Health research**—Organized hospital research program in any of the following areas: basic research, clinical research, community health research, and/or research on innovative health care delivery.

**Health screenings**—A preliminary procedure such as a test or examination to detect the most characteristic sign or signs of a disorder that may require further investigation.

**Heart transplant**—The branch of medicine that transfers a heart organ or tissue from one person to another or from one part to another to replace a diseased structure or to restore function or to change appearance.

**Hemodialysis**—Provision of equipment and personnel for the treatment of renal insufficiency on an inpatient or outpatient basis.

**HIV-AIDS services**—Special unit or team designated and equipped specifically for diagnosis, treatment, continuing care planning, and counseling services for HIV-AIDS patients and their families. General inpatient care for HIV-AIDS-Inpatient diagnosis and treatment for human

immunodeficiency virus and acquired immunodeficiency syndrome patients, but dedicated unit is not available. Specialized outpatient program for HIV-AIDS-Special outpatient program providing diagnostic, treatment, continuing care planning, and counseling for HIV-AIDS patients and their families.

**Home health services**—Service providing nursing, therapy, and health-related homemaker or social services in the patient's home.

**Hospice Program**—A recognized clinical program with specific eligibility criteria that provides palliative medical care focused on relief of pain and symptom control and other services that address the emotional, social, financial and spiritual needs of terminally ill patients and their families. Hospice care can be provided either at home, in a hospital setting, or a free-standing facility.

**Hospital size**—Hospital size is based on bed size as follows: small – under 100 beds; medium – 100-399 beds; large – 400+ beds.

**Hospital-base outpatient care center/services**—Organized hospital health care services offered by appointment on an ambulatory basis. Services may include outpatient surgery, examination, diagnosis, and treatment of a variety of medical conditions on a nonemergency basis, and laboratory and other diagnostic testing as ordered by staff or outside physician referral.

**I**

**Image-guided radiation therapy**—Automated system for image-guided radiation therapy that enables clinicians to obtain high-resolution x-ray images to pinpoint tumor sites, adjust patient positioning when necessary, and complete a treatment, all within the standard treatment time slot, allowing for more effective cancer treatments.

**Immunization program**—Program that plans, coordinates and conducts immunization services in the community.

**Indemnity fee for service plan (JV)**—The traditional type of health insurance, in which the insured is reimbursed for covered expenses without regard to choice of provider. Payment up to a stated limit may be made either to the individual incurring and claiming the expense, or directly to providers.

**Indigent care clinic**—Health care services for uninsured and underinsured persons where care is free of charge or charged on a sliding scale. This would include free clinics staffed by volunteer practitioners, but could also be staffed by employees with the sponsoring health care organization subsidizing the cost of service.

**Inpatient Days**—The number of adult and pediatric days of care, excluding newborn days of care, rendered during the entire reporting period.

**Inpatient palliative care unit**—An inpatient palliative care ward is a physically discreet, inpatient nursing unit where the focus is palliative care. The patient care focus is on symptom relief for complex patients who may be continuing to undergo primary treatment. Care is delivered by palliative medicine specialists.

**Integrated salary model**—Hospital has an arrangement in place whereby physicians are salaried by the hospital or another entity of a health system to provide medical services for primary care and specialty care.

**Intensity-Modulated Radiation Therapy (IMRT)**—A type of three-dimensional radiation therapy, which improves the targeting of treatment delivery in a way that is likely to decrease damage to normal tissues and allows varying intensities.

**Intermediate nursing care**—Provides health-related services (skilled nursing care and social services) to residents with a variety of physical conditions or functional disabilities. These residents do not require the care provided by a hospital or skilled nursing facility, but do need supervision and support services.

**Intraoperative magnetic resonance imaging**—An integrated surgery system which provides an MRI system in an operating room. The system allows for immediate evaluation of the degree to tumor resection while the patient is undergoing a surgical resection. Intraoperative MRI exists when a MRI (low-field or high-field) is placed in the operating theater and is used during surgical resection without moving the patient from the operating room to the diagnostic imaging suite.

**Investor-owned for-profit**—The number of investor-owned, for profit hospitals in the system.

**K**

**Kidney transplant**—The branch of medicine that transfers a kidney organ or tissue from one person to another or from one part to another to replace a diseased structure or to restore function or to change appearance.

**L**

**Length of Stay**—Length of Stay (LOS) refers to the average number of days a patient stays at the facility.

**Linguistic/translation services**—Services provided by the hospital designed to make health care more accessible to non-English speaking patients and their physicians.

**Liver transplant**—The branch of medicine that transfers a liver organ or tissue from one person to another or from one part to another to replace a diseased structure or to restore function or to change appearance.

**Lung transplant**—The branch of medicine that transfers a lung organ or tissue from one person to another or from one part to another to replace a diseased structure or to restore function or to change appearance.

**M**

**Magnetic resonance imaging (MRI)**—The use of a uniform magnetic field and radio frequencies to study tissue and structure of the body. This procedure enables the visualization of biochemical activity

of the cell in vivo without the use of ionizing radiation, radioisotopic substances, or high-frequency sound.

**Meals on wheels**—A hospital-sponsored program which delivers meals to people, usually the elderly, who are unable to prepare their own meals. Low cost, nutritional meals are delivered to individuals' homes on a regular basis.

**Medical surgical intensive care**—Intensivists are board-certified physicians who are additionally certified in the subspecialty of critical care medicine; or physicians board-certified in emergency medicine who have completed a critical care fellowship in an ACGME accredited program; or physicians board-certified in Medicine, Anesthesiology, Pediatrics or Surgery who completed training prior to the availability of subspecialty certification in critical care and who have provided at least six weeks of full-time ICU care annually since 1987.

**Medical/surgical intensive care**—Provides patient care of a more intensive nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. These units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who because of shock, trauma or other life-threatening conditions require intensified comprehensive observation and care. Includes mixed intensive care units.

**Mobile Health Services**—Vans and other vehicles used to deliver primary care services.

**Multi-slice spiral computed tomography < 64 slice**—A specialized computer tomography procedure that provides three-dimensional processing and allows narrower and multiple slices with increased spatial resolution and faster scanning times as compared to a regular computer tomography scan.

**Multi-slice spiral computed tomography 64 + slice**—Involves the acquisition of volumetric tomographic x-ray absorption data expressed in Hounsfield units using multiple rows of detectors. 64+ systems reconstruct the equivalent of 64 or greater slices to cover the imaged volume.

**N**

**Neonatal intensive care**—A unit that must be separate from the newborn nursery providing intensive care to all sick infants including those with the very lowest birth weights (less than 1500 grams). NICU has potential for providing mechanical ventilation, neonatal surgery, and special care for the sickest infants born in the hospital or transferred from another institution. A full-time neonatologist serves as director of the NICU.

**Neonatal intermediate care**—A unit that must be separate from the normal newborn nursery and that provides intermediate and/or recover care and some specialized services, including immediate resuscitation, intravenous therapy, and capacity for prolonged oxygen therapy and monitoring.

**Network member**—A group of hospitals, physicians, other providers, insurers and/or community agencies that voluntarily work together to coordinate and deliver health services.

**Neurological services**—Services provided by the hospital dealing with the operative and nonoperative management of disorders of the central, peripheral, and autonomic nervous system.

**Nutrition program**—Those services within a health care facility which are designed to provide inexpensive, nutritionally sound meals to patients.

**O**

**Obstetrics care**—Provides care, examination, treatment, and other services to women during pregnancy, labor, and the puerperium.

**Occupational health services**—Includes services designed to protect the safety of employees from hazards in the work environment.

**Oncology services**—Inpatient and outpatient services for patients with cancer, including comprehensive care, support and guidance in addition to patient education and prevention, chemotherapy, counseling and other treatment methods.

**Optical Colonoscopy**—An examination of the interior of the colon using a long, flexible, lighted tube with a small built-in camera.

**Orthopedic services**—Services provided for the prevention or correction of injuries or disorders of the skeletal system and associated muscles, joints and ligaments

**Other special care**—Provides care to patients requiring care more intensive than that provided in the acute area, yet not sufficiently intensive to require admission to an intensive care unit. Patients admitted to this area are usually transferred here from an intensive care unit once their condition has improved. These units are sometimes referred to as definitive observation, step-down or progressive care units.

**Other Transplant – hospital**—Other transplant services includes heart/lung, or other multi-transplant surgeries.

**Outpatient surgery**—Scheduled surgical services provided to patients who do not remain in the hospital overnight. The surgery may be performed in operating suites also used for inpatient surgery, specially designated surgical suites for outpatient surgery, or procedure rooms within an outpatient care facility.

**P**

**Pain Management Program**—A recognized clinical service or program providing specialized medical care, drugs or therapies for the management of acute or chronic pain and other distressing symptoms, administered by specially trained physicians and other clinicians, to patients suffering from an acute illness of diverse causes.

**Palliative Care Program**—An organized program providing specialized medical care, drugs or therapies for the management of acute or chronic pain and/or the control of symptoms administered by specially trained physicians and other clinicians; and supportive care services, such as counseling on advanced directives, spiritual care, and social services, to patients with advanced disease and their families.

**Patient Controlled Analgesia**—Patient-controlled Analgesia (PCA) is intravenously administered pain medicine under the patient's control. The patient has a button on the end of a cord than can be pushed at will, whenever more pain medicine is desired. This button will only deliver more pain medicine at pre-determined intervals, as programmed by the doctor's order.

**Patient education center**—Written goals and objectives for the patient and/or family related to therapeutic regimens, medical procedures, and self care.

**Patient representative services**—Organized hospital services providing personnel through whom patients and staff can seek solutions to institutional problems affecting the delivery of high-quality care and services.

**Pediatric cardiac electrophysiology**—Evaluation and management of pediatric patients with complex rhythm or conduction abnormalities, including diagnostic testing, treatment of arrhythmias by catheter ablation or drug therapy, and pacemaker/defibrillator implantation and follow-up.

**Pediatric cardiac surgery – hospital**—Includes minimally invasive procedures that include surgery done with only a small incision or no incision at all, such as through a laparoscope or an endoscope and more invasive major surgical procedures that include open chest and open heart surgery.

**Pediatric cardiology services**—An organized clinical service offering diagnostic and intervention procedures to manage the full range of pediatric heart conditions.

**Pediatric diagnostic catheterization**—Cardiac angiography, also called coronary angiography or coronary arteriography, is used to assist in diagnosing complex heart conditions. It involves the insertion of a tiny catheter into the artery in the groin then carefully threading the catheter up into the aorta where the coronary arteries originate. Once the catheter is in place, a dye is injected which allows the cardiologist to see the size, shape, and distribution of the coronary arteries. Images are used to diagnose heart disease and to determine, whether or not surgery is indicated.

**Pediatric intensive care**—Provides care to pediatric patients that is of a more intensive nature than that usually provided to pediatric patients. The unit is staffed with specially trained personnel and contains monitoring and specialized support equipment for treatment of patients who, because of shock, trauma, or other life-threatening conditions, require intensified, comprehensive observation and care.

**Pediatric interventional cardiac catheterization**—Non surgical procedure that utilizes the same basic principles as diagnostic catheterization and then uses advanced techniques to improve the heart's function. It can be a less-invasive alternative to heart surgery.

**Physical Rehabilitation care**—Provides care encompassing a comprehensive array of restoration services for the disabled and all support services necessary to help patients attain their maximum functional capacity.

**Physical rehabilitation outpatient services**—Outpatient program providing medical, health-related, therapy, social, and/or vocational services to help disabled persons attain or retain their maximum functional capacity.

**Positron emission tomography (PET)**—Positron emission tomography scanner is a nuclear medicine imaging technology which uses radioactive (positron emitting) isotopes created in a cyclotron or generator and computers to produce composite pictures of the brain and heart at work. PET scanning produces sectional images depicting metabolic activity or blood flow rather than anatomy.

**Positron emission tomography/CT (PET/CT)**—Provides metabolic functional information for the monitoring of chemotherapy, radiotherapy, and surgical planning.

**Primary care department**—A unit or clinic within the hospital that provides primary care services (e.g. general pediatric care, general internal medicine, family practice, gynecology) through hospital-salaried medical and/or nursing staff, focusing on evaluating and diagnosing medical problems and providing medical treatment on an outpatient basis.

**Prosthetic and orthotic services**—Services providing comprehensive prosthetic and orthotic evaluation, fitting, and training.

**Proton beam therapy**—A form of radiation therapy which administers proton beams. While producing the same biologic effects as x-ray beams, the energy distribution of protons differs from conventional x-ray beams in that they can be more precisely focused in tissue volumes in a three-dimensional pattern resulting in less surrounding tissue damage than conventional radiation therapy permitting administration of higher doses.

**Psychiatric care**—Provides acute or long-term care to emotionally disturbed patients, including patients admitted for diagnosis and those admitted for treatment of psychiatric problems, on the basis of physicians' orders and approved nursing care plans. Long-term care may include intensive supervision to the chronically mentally ill, mentally disordered, or other mentally incompetent persons.

**Psychiatric child/adolescent services**—Provides care to emotionally disturbed children and adolescents, including those admitted for diagnosis and those admitted for treatment.

**Psychiatric consultation/liaison services**—Provides organized psychiatric consultation/liaison services to nonpsychiatric hospital staff and/or departments on psychological aspects of medical care that may be generic or specific to individual patients.

**Psychiatric education services**—Provides psychiatric educational services to community agencies and workers such as schools, police, courts, public health nurses, welfare agencies, clergy, and so forth. The purpose is to expand the mental health knowledge and competence of personnel not working in the mental health field and to promote good mental health through improved understanding, attitudes, and behavioral patterns.

**Psychiatric emergency services**—Services of facilities available on a 24-hour basis to provide immediate unscheduled out-patient care, diagnosis, evaluation, crisis intervention, and assistance to persons suffering acute emotional or mental distress.

**Psychiatric geriatric services**—Provides care to emotionally disturbed elderly patients, including those admitted for diagnosis and those admitted for treatment.

**Psychiatric outpatient services**—Provides medical care, including diagnosis and treatment, of psychiatric outpatients.

**Psychiatric partial hospitalization program**—Organized hospital services of intensive day/evening outpatient services of three hours of more duration, distinguished from other outpatient visits of one hour.

**R**

**Retirement housing**—A facility that provides social activities to senior citizens, usually retired persons, who do not require health care but some short-term skilled nursing care may be provided. A retirement center may furnish housing and may also have acute hospital and long-term care facilities, or it may arrange for acute and long-term care through affiliated institutions.

**Robot-assisted walking therapy**—A form of physical therapy that uses a robotic device to assist patients who are relearning how to walk.

**Robotic surgery**—The use of mechanical guidance devices to remotely manipulate surgical instrumentation.

**S**

**Shaped beam Radiation System**—A precise, non-invasive treatment that involves targeting beams of radiation that mirror the exact size and shape of a tumor at a specific area of a tumor to shrink or destroy cancerous cells. This procedure delivers a therapeutic dose of radiation that conforms precisely to the shape of the tumor, thus minimizing the risk to nearby tissues.

**Simulated rehabilitation environment**—Rehabilitation focused on retraining functional skills in a contextually appropriate environment (simulated home and community settings) or in a traditional setting
(gymnasium) using motor learning principles.

**Single photon emission computerized tomography (SPECT)**—Single photon emission computerized tomography is a nuclear medicine imaging technology that combines existing technology of gamma camera imaging with computed tomographic imaging technology to provide a more precise and clear image.

**Skilled nursing care**—Provides non-acute medical and skilled nursing care services, therapy, and social services under the supervision of a licensed registered nurse on a 24-hour basis.

**Sleep Center**—Specially equipped and staffed center for the diagnosis and treatment of sleep disorders.

**Social work services**—Organized services that are properly directed and sufficiently staffed by qualified individuals who provide assistance and counseling to patients and their families in dealing

with social, emotional, and environmental problems associated with illness or disability, often in the context of financial or discharge planning coordination.

**Sports medicine**—Provision of diagnostic screening and assessment and clinical and rehabilitation services for the prevention and treatment of sports-related injuries.

**Stereotactic radiosurgery**—Stereotactic radiosurgery (SRS) is a radiotherapy modality that delivers a high dosage of radiation to a discrete treatment area in as few as one treatment session. Includes gamma knife, cyberknife, etc.

**Support groups**—A hospital-sponsored program that allows a group of individuals with the same or similar problems who meet periodically to share experiences, problems, and solutions in order to support each other.

**Surgical operations (inpatient)**—Surgical services provided to patients who remain in the hospital overnight.

**Swing bed services**—A hospital bed that can be used to provide either acute or long-term care depending on community or patient needs. To be eligible a hospital must have a Medicare provider agreement in place, have fewer than 100 beds, be located in a rural area, do not have a 24 hour nursing service waiver in effect, have not been terminated from the program in the prior two years, and meet various service conditions.

**System Classification**—A health system is assigned to one of five categories based on how much they differentiate and centralize their hospital services, physician arrangements, and provider-based insurance products. Differentiation refers to the number of different products or services that the organization offers. Centralization refers to whether decision-making and service delivery emanates from the system level more so than individual hospitals.

**System member**—Indicates whether a hospital is affiliated with a healthcare system. A multihospital health care system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization.

**T**

**Teaching Affiliation**—Major Teaching Hospitals - those with Council of Teaching Hospitals designation Minor Teaching Hospitals - those either Approved to participate in residency and/or internship training by the Accreditation Council for Graduate Medical Education, or those with medical school affiliation reported to the American Medical Association Non Teaching Hospitals - those without COTH, ACGME, or Medical School (AMA) affiliation.

**Teen outreach services**—A program focusing on the teenager which encourages an improved health status and a healthful lifestyle including physical, emotional, mental, social, spiritual and economic health through education, exercise, nutrition and health promotion.

**Tissue transplant**—The branch of medicine that transfers tissue from one person to another or from one part to another to replace a diseased structure or to restore function or to change appearance.

**Tobacco Treatment Services**—Organized hospital services with the purpose of ending tobacco-use habits of patients addicted to tobacco/nicotine.

**Total births (excluding fetal deaths)**—Total number of infants born in the hospital during the reporting period, excluding fetal deaths. Births do not include infants transferred from other institutions, and are excluded from admission and discharge figures.

**Total hospital beds**—Number of beds regularly maintained (set up and staffed for use) for inpatients as of the close of the reporting period. Excludes newborn bassinets.

**Transportation to health services**—A long-term care support service designed to assist the mobility of the elderly. Some programs offer improved financial access by offering reduced rates and barrier-free buses or vans with ramps and lifts to assist the elderly or handicapped; others offer subsidies for public transport systems or operate mini-bus services exclusively for use by senior citizens.

**U**

**Ultrasound**—The use of acoustic waves above the range of 20,000 cycles per second to visualize internal body structures.

**Urgent care center**—A facility that provides care and treatment for problems that are not life-threatening but require attention over the short term. These units function like emergency rooms but are separate from hospitals with which they may have backup affiliation arrangements.

**V**

**Virtual colonoscopy**—Noninvasive screening procedure used to visualize, analyze and detect cancerous or potentially cancerous polyps in the colon.

**Volunteer services department**—An organized hospital department responsible for coordinating the services of volunteers working within the institution.

**W**

**Women's health center/services**—An area set aside for coordinated education and treatment services specifically for and promoted to women as provided by this special unit. Services may or may not include obstetrics but include a range of services other than OB.

**Wound Management Services – hospital**—Services for patients with chronic wounds and non-healing wounds often resulting from diabetes, poor circulation, improper seating and immunocompromising conditions.