Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – October 1st, 2007

Healthcare Without Prevention Misses Target

by Tim Size, RWHC Executive Director

Along with going cold turkey from the Internet for a week, one of my summer rituals is to review the University of Wisconsin Population Health Institute report, "Wisconsin County Health Rankings." This county by county comparison of health is unique in the view it gives us of our state—it is intended "to summarize the current state of health and distribution of key factors that determine health." Like any report of this type, there are limitations and the reader is left with as many questions as answers. Which is the point—the report isn't intended to be the last word, but to begin long overdue local community conversations.

"Sure we can just keep dousing fires, or we can find the kid with the matches."

What struck me this year is that the report has two halves, that must be seen as complementary. Not made explicit, but easy enough to calculate is the following: three-quarters of Wisconsin's urban counties have health outcomes that are better than average while only one-third of rural counties can say the same. At first glance, not a rural health success story. But before rural Wisconsin healthcare providers get defensive, lets look at the rest of the story.

In addition to calculating "health status" the report also shows a ranking of key factors that are thought to determine health status in each county. The ranking is based on the University's best guess of the relative weight or importance of four key factors: 10% for health care, 40% for health behaviors, 40% for socio-economic factors, and 10% for the physical environment. When you look at these rankings, three-quarters of Wisconsin's urban counties have health "determinants" that are better than average while only one-third of rural counties do. If you follow the math, there is a simple bottom line; rural counties are predicted to have worse health status and they do. Because individual behaviors like smoking and exercising matter, as do education, jobs and income—the cumulative effect can be, quite literally, deadly.

Does this let rural healthcare providers off the hook? I don't think so. It just means we have a large hook with plenty of room for company. Some "healthcare reform" advocates figure if everyone has health insurance and healthcare providers can be properly "controlled," problem solved! As one prominent state supporter of single payer health care once asked me, "what am I supposed to do, campaign door to door and tell folks to 'drop the donut.' " No, but we need to get real. Healthcare reform isn't health reform. What we care about is our health and the health of our family, friends and neighbors. It is the lack of community health that drives costs that we increasingly can no longer afford.

With over thirty years of more than a little disagreement with the American Hospital Association (AHA), I now have to say that miracle of miracles, we couldn't agree more. Perhaps I am mellowing but the AHA is definitely on target when they call for America's hos-

pitals to get serious about individual and community wellness. They have begun to circulate a framework for health reform that makes more sense than anything I have seen to date, *"Health for Life, Better Health, Better Health Care"*—a set of goals and an agenda for creating better, safer, more affordable care and a healthier America. It is a work in progress; their stated objective is to be a "catalyst for change."

From AHA: "Without change, America's health care capabilities and finances will be overwhelmed. As a society we must: provide access to education and preventive care, help all reach their highest potential for health and reverse the trend of avoidable illness. As individuals we must achieve healthier lifestyles, take responsibility for our health behaviors and choices and each one of us must take action… Chronic illness is on the rise, half of Americans have one or more chronic illnesses; 80% of spending is linked to chronic illness, much of this is avoidable; obesity has doubled; diabetes is on the rise… Not all illness is preventable. But good primary care, health education and a healthy lifestyle are essential to improving health. Costs for health coverage and health care can be controlled as health improves."

Real reform must address universal access to healthcare and yes, the cost of healthcare. But equally important, it must focus on what individuals and communities can do to become significantly more healthy and less dependent on what will always be very expensive medical interventions. To do less is not reform, but a collective self-deception we can't afford.

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

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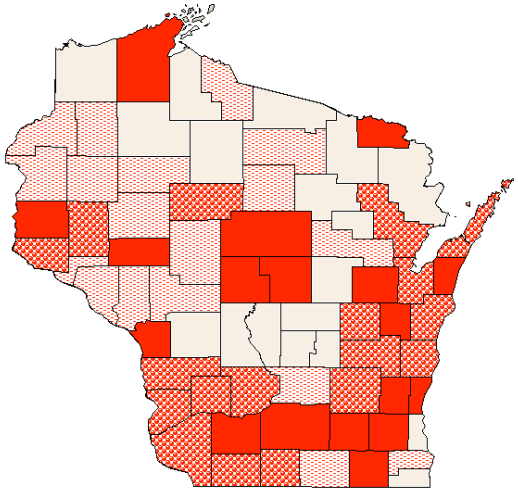
Rural Wisconsin Expected To Have Lower Than Average Health & It Does

Three-quarters of Wisconsin's urban counties have health outcomes that are better than average while only one-third of rural counties can say the same. No surprise here as three-quarters of Wisconsin's urban counties have health "determinants" that are better than average while only one-third of rural counties do. Determinants are factors that are thought to determine health status like individual behaviors, education and income.



Worst Quartile (white) Second Quartile (red)
Third Quartile (redder) Best Quartile (reddest)

Calculated from the 2007 *"Wisconsin County Health Rankings,"* University of Wisconsin Population Health Institute

Links to Above Referenced Reports

"Health for Life, Better Health, Better Health Care"
http://www.aha.org/aha/issues/

"Wisconsin County Health Rankings"
http://www.pophealth.wisc.edu/uwphi/

Links to Employer Wellness Resources

"Big Steps For Small Business—10 Health Promotion Programming Ideas Every Small Business Should Consider" It's no secret that health promotion has been embraced by the business community in a big way. However, even though companies are participating in worksite wellness now more than ever before, many small businesses are still on the outside looking in. In fact, very little has been written specifically for small businesses to help them in their quest to create healthier employees and healthier

companies. In this free article, there are 10 programming ideas that can make a big difference in any small company. **http://www.welcoa.org/**

"The 2nd Edition of the Wisconsin Worksite Wellness Resource Kit" is available with additional information added based on input from worksites. The kit is a tool to assist worksites with implementing strategies that have been proven to be effective, walking you through the process of developing a worksite wellness program. Google <Wisconsin physical activity>

Wellness Councils of America
http://www.welcoa.org/

Wellness Councils of America, Wisconsin Affiliate
http://www.wellnesscouncilwi.org/

Workplace Solutions, Building A Healthy Worforce
http://www.acsworkplacesolutions.com/

Partnership for Prevention **http://www.prevent.org/**

As a nod to the "Fairness Doctrine" but mostly because they are really funny, here are two examples of some fast food corporations' "interest" in community & employer wellness initiatives. Remember to make subliminal messages explicit is to remove their power; in any event no one knows us better than commercial marketers. Watch the Center for Consumer Freedom's "Food Police" Video (30 sec) by googling <"food police" "youtube"> and Burger King's "I Am Man" Video (60 sec) by googling <"I Am Man" "Burger King">.

Local Pharmacists Being Forced Out

From "Small-town pharmacists closing doors" by Kevin Freking, Associated Press Writer, 9/17/07:

"After nearly 25 years as the proud owner of Home Town Drugs and Gifts in Sweet Home, Ore., Dave Redden closed down this summer, joining a growing trend among small-town pharmacists. Competition from mail-order pharmacies and larger retailers played a role in his decision. So did the long hours that came from running a business."

"But Redden, 62, said one factor, the Medicare drug benefit, outweighed them all. Before the benefit started on Jan. 1, 2006, many of his customers paid cash. Under the new system, private insurance plans pick up much of the tab. That was good news for the customers; not so for Redden. The insurers used their considerable clout to demand bigger discounts. Plus, they did not have to pay Redden right away. The pharmacist said he often waited months for insurance plans to reimburse him."

"Redden's bills did not wait, however. He took out loans to ease the cash flow crunch. First for $50,000, then a second for $60,000. The interest further reduced his profit margin. Eventually, he had enough. ' It just got hard to be continually borrowing money and getting more into debt and not seeing any light at the end of the tunnel,' Redden said in a telephone interview."

"Lobbying groups representing pharmacists say Redden's case highlights a serious decline in the ranks of independent pharmacists. About 5 percent of independent pharmacies, or 1,152, went out of business last year, according to the National Community Pharmacists Association. The association says the Medicare drug benefit, known as Medicare Part D, led to lower and slower payments to pharmacists. The group wants Congress to pass legislation that would require Medicare's drug plans to reimburse pharmacists within 14 days of an electronic submission of a claim and within 30 days of all other submissions."

"Opposition to the legislation comes from the insurance industry and the middlemen they hire to manage a plan's drug benefit, pharmaceutical benefit managers. Currently, Medicare and the private sector routinely use a 30-day standard when paying doctors and hospitals, so insurers should not be treated differently, the bill's opponents say."

"While the Medicare drug plans maintain they pay pharmacists promptly, a University of Texas study commissioned by the pharmacists found that wasn't the case. The university's researchers studied about 3 million prescription drug claims submitted last year by independent and chain pharmacies. They found

that less than 1 percent of claims were paid within two weeks, while 44.1 percent were paid after more than 30 days."

"Pharmacists argue that insurers have an economic incentive to delay payment. They get millions of dollars from the federal government and from Medicare beneficiaries for administering the drug benefit. The longer they hold on to that money, the more interest that money can generate. 'They get paid up front and they have a vested interest in sitting on that money as long as possible,' said Charlie Sewell, from the National Community Pharmacists Association."

Private Insurers' Growing Share of Medicare

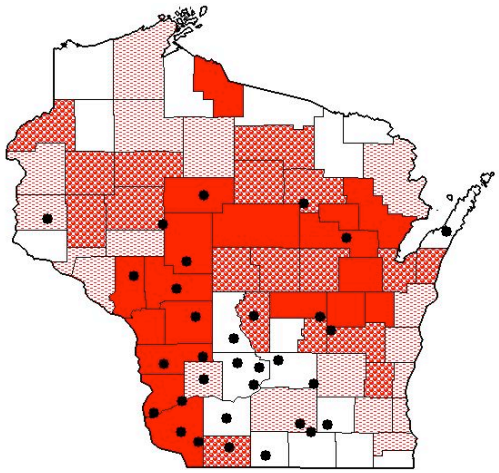
From "Rural Enrollment in Medicare Advantage Growing Rapidly in 2007" by Timothy D. McBride, Ph.D., Tanchica L. Terry, M.A., Keith J. Mueller, Ph.D. in a RUPRI Center for Rural Health Policy Analysis *Rural Policy Brief*, 7/07:

Enrollment in Medicare Advantage (MA) plans has more than tripled since the inception of the MA program at the beginning of 2006. However, rural enrollment remains well below urban enrollment as a percentage of the eligible population. This policy brief provides findings about enrollment in the newly designed MA program in rural and urban areas across the United States and updates earlier related findings from previous RUPRI Center policy briefs."

Key Findings (as of the 6/5/07 CMS data release)

- "Over 780,000 rural Medicare beneficiaries were enrolled in an MA plan, an increase of 50% since November 2006, and a 222% increase since 2005."
- "Despite significant growth in MA plans, only 8.6% of rural persons were enrolled in MA plans in June 2007, compared to 21.7% of urban persons."
- "Over half (55%) of rural persons enrolled in MA or prepaid plans were in private fee-for-service (PFFS) plans, compared to 14% of urban persons."
- "PFFS enrollment in rural areas in June 2007 was concentrated in several PFFS plans, with almost 90% of rural persons enrolled in plans run by seven organizations serving about 2,000 counties in the United States."

WISC Medicare Advantage Market Penetration
Medicare Advantage Market Share by County

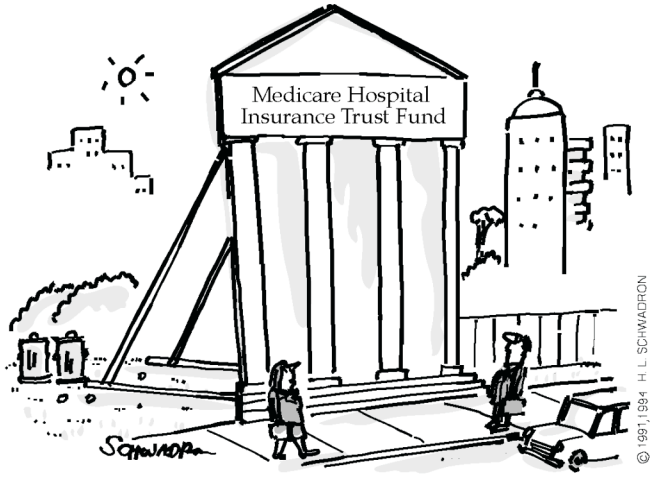


(Wisconsin Average = 21%) Estimates as of 7/07

Lowest Quartile (white):	7%	to 17%
Second Quartile:	17%	to 21%
Third Quartile:	21%	to 28%
Highest Quartile (red):	28%	to 55%

- RWHC Member Hospitals

RWHC Eye On Health



"No problem, it isn't bankrupt for a good ten years."

$1.6 Million Grant Boosts RWHC HIT Plan

From "Rural hospitals to get wired for info sharing" by Anita Weier in the *Capital Times*, 9/12/07:

"Rural hospitals sometimes have trouble paying for the technological advances that come more easily to larger institutions with bigger budgets."

"But Wisconsin's rural hospitals just received a big boost with a $1.6 million federal grant that will help them cooperatively implement electronic medical records systems. The grant from the U.S. Department of Health and Human Services went to the Rural Wisconsin Health Cooperative and the Wisconsin Office of Rural Health. It will be used to help develop a shared hospital information system."

" 'Participating hospitals will share some staff and computers as they work on developing a high-quality system that will save money,' said Louis Wenzlow, director of health information technology for the Sauk City-based 32-member cooperative. The hospitals also were able to negotiate steep discounts on the software that will be used."

"The grant will launch the Rural Wisconsin Health Cooperative Information Technology Network, a nonprofit cooperative owned by participating nonprofit hospitals. The network will serve rural hospitals and doctors by providing:

- Integrated electronic info to support health care.
- Systems to reduce avoidable medication errors.
- Affordable and effective electronic health records and quality support to ensure appropriate use."

" 'Individual hospitals might only be able to assign one person to work on complicated information systems, so sharing staff will allow the hospitals to build up expertise,' Wenzlow said. The Rural Wisconsin Health Cooperative has been working on the initiative for years, said Executive Director Tim Size. 'This federal support will go a long way to help achieve our vision to create an affordable high quality information network for rural Wisconsin hospitals and their patients.' "

"Participation in the network will be open to all rural hospitals. The first members are St. Joseph's Health Services in Hillsboro, Tomah Memorial hospital and Memorial Hospital of Lafayette County in Darlington. The organization eventually intends to work with larger hospitals toward a regional data exchange that will further enhance patient safety and health care system efficiency, officials said."

Shared staffing will be based out of the RWHC offices in Sauk City. "The main computers will be in a vault provided by a private corporation in Madison; a backup system in Sauk City will protect information in case of a failure in the main system. 'Patient privacy will be protected with security systems that will restrict access to clinical information to doctors who need it,' Wenzlow said."

For more information, please contact RWHC Director of HIT, Louis Wenzlow at ***lwenzlow@rwhc.com***

Wisconsin Extends Nurse Residency Grant

The Wisconsin Nurse Residency Program Grant has been awarded an extension grant: "Wisconsin Nurse Residency Program, Continuing Partnerships to Support New Nurses' Seamless Transition in Practice."

It is funded by the Federal Health Resources and Services Administration and began July 1, 2007, running for three years. Marilyn Bratt, PhD, RN will continue as the Project Director.

Like the prior grant, the development and delivery of the program objectives will be a collaborative project with the following organizations participating: Aspirus Wausau Hospital, Community Memorial Hospital, Cumberland and other Northwest Rural Hospitals, Theda Care, St. Vincent Hospital, Wheaten-Francisican Healthcare-All Saints and the RWHC member organizations.

The focus of this grant is to provide education to preceptors, the people training new nurse during the initial orientation as well as when nurses orient to a specialty unit. The grant will also fund additional education offerings for clinical coaches, who are experi-

enced nurses who "coach" new nurses, a role similar to a mentor. A focus will be to use the new simulation technology, where preceptors as well as clinical coaches can be given immediate feedback after enacting their roles in a clinical or professional situation using a simulated dummy.

Wisconsin Division of Quality Assurance "Demystifying Hospital Regulations" Thursday, October 25th in Madison
http://dhfs.wisconsin.gov/rl_dsl/training

The program funded by the first grant continues to be supported by rural hospitals as the RWHC Nurse Residency Program. This year's session started in July with forty-five nurse residents participating. The first of twelve learning days is scheduled on September 25th. Due to the maximum doable class size, RWHC had to close enrollment in mid-August.

For more information, please call Cheryl Pedersen, RWHC Nursing Consultant, at (608) 643-2343, or e-mail at ***cpedersen@rwhc.com***

Rural Hospitals Benefit From AHEC Support

The Rural Wisconsin Health Cooperative (RWHC) recently wrapped up a year-long, health professions education program made possible through financial support from Southwest Wisconsin Area Health Education Center (SWAHEC). The main objective of the "RWHC Mediasite Project" was to create and expand learning opportunities for rural health professionals through the development of a continuing medical education (CME) library.

Thirty two RWHC hospitals accessed over 21 hours of original programming in the areas of: coding/discharge guidelines, pediatric care, diabetes updates, septic shock, the methamphetamine epidemic, and others. Remote access to these programs was made possible through Mediasite technology—a fully integrated, portable media system that allows for the recording, distribution and management of educational content.

In addition to program development, SWAHEC funding was used to develop "post tests" for each program and process CME/CEU credit applications. Both organizations (RWHC and SWAHEC) will continue to collaborate in the area of health education whenever opportunities present themselves.

Wisconsin's Health Services Youth Apprenticeship Program
http://dwd.wisconsin.gov/youthapprenticeship/

Wisconsin's Youth Apprenticeship program is designed for high school students who want to experience hands on learning at the worksite in conjunction with classroom instruction. This rigorous two year elective program combines academic and technical instruction with mentored on-the-job learning that makes a real world connection for the students. **The new Health Services Program Guide is now available on-line at this site.**

The Bias Against Funding Rural Projects

From the "Rural Philanthropy: Building Dialogue From Within" by the National Committee for Responsive Philanthropy; the 48 page report is available free online at **http://www.ncrp.org/** :

"Current grantmaking behavior and trends are skewed heavily toward support for urban based or urban-focused programs. In *Rural Philanthropy: Building Dialogue from Within*, the National Committee for Responsive Philanthropy explores both real and perceived barriers between rural nonprofits and foundations in urban areas, as well as strategies for overcoming those obstacles."

"NCRP's research revealed that rural nonprofit directors and seasoned rural grantmakers agree on many of the obstacles that deter foundations from engaging in more aggressive rural grantmaking. Overwhelmingly positive and negative perceptions and stereotypes of rural America may deter foundations from supporting rural causes and nonprofits. In addition, foundations agree that it is important for nonprofits to build relationships with grantmakers to secure funding, but rural nonprofits have little or no access to major foundations. Foundations also look to achieve the greatest impact by funding dense populations, which rural areas don't have."

"Moreover, funders perceive a lack of organizational capacity and sophistication among rural nonprofits, which raises serious concerns regarding the level of effectiveness and sustainability of potential

rural recipients. Finally, rural nonprofits that are located far from major metropolitan areas are most likely to operate without the benefit of a strong local nonprofit infrastructure."

"NCRP's research identified four strategies for strengthening rural philanthropy, and assessed the effectiveness of each."

"The first strategy is to use flexible multiyear core grantmaking that sufficiently allows rural nonprofits to hire and retain needed staff, and to seek appropriate technical assistance. Also, when rural organizations have foundation support for "organizational slack" and building reserves, they are more likely to survive times of crises and turbulence."

"The second strategy is to use regranting and capacity building intermediaries, which are important delivery systems in rural areas when foundations lack the internal capacity to meet grantee funding and capacity needs."

"A third strategy is the use of funding collaboratives to increase flexible grantmaking to rural areas by drawing in foundations that are not already active rural grantmakers."

"Finally, research suggests that local endowment-building as a rural philanthropic strategy does not address pressing, current local needs and opportunities, and has serious limitations without the help of large foundations.

Rural Philanthropy: Building Dialogue from Within was funded by the W. K. Kellogg Foundation."

Rural Hospitals & Their Larger Community

Each Month, "Eye On Health" will showcase a RWHC Hospital story from the Wisconsin Hospital Associations' annual Community Benefits Report. Wisconsin hospitals provide $1.6 Billion in community benefit; twice that if you include Medicare shortfalls and bad debt. This month's feature is from Upland Hills Health, Dodgeville, "Donation To Free Clinic Seen As A Worthy Investment In Community Health":

RWHC Eye On Health

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

"At the June 2007 meeting the Upland Hills Health Board of Directors, they agreed to make a donation of $35,000 for the Community Connections Free Clinic."

"The donation will allow the clinic to move from the cramped 1st floor area it shares with other community resources to the ground floor of the Iowa Street building it occupies in Dodgeville."

"Specifically the money will be used for water remediation and trenching in the concrete floor. Once this is complete the Free Clinic will be able to proceed with its expansion plans."

"Right now the Free Clinic occupies two exam rooms and minimal common space. By remodeling the ground floor of the building, the Free Clinic will be able to expand to four larger exam rooms and serve more uninsured, low income patients. This also makes room for a proposed dental clinic for Medicaid recipients with four dental chairs and a common area shared by the medical and dental clinics."

" 'It is in our community's best interest to see that the Free Clinic is successful,' said Karl Pustina, CFO of Upland Hills Health, 'We are committed to finding solutions that will address the health care needs of our community. This donation demonstrates just that.' In addition, Upland Hills Health donates $60,000 worth of lab and radiology service annually to the Community Connections Free Clinic."

RWHC Passages of Friends

From Tim Size, RWHC Executive Director:

Bill Beach, Sauk Prairie Memorial Hospital administrator from 1967-1995, died suddenly Tuesday, August 21. Bill was simply a great friend and mentor; for many of us, for RWHC and for rural health. In more ways than one, time after time, he was a rural hospital administrator's administrator.

George Johnson, president of the Reedsburg Medical Center since 1980, was awarded the 2007 Distinguished Service Award as well as a Lifetime Achievement Award at the Annual Convention of the Wisconsin Hospital Association (WHA). As George moves on later this year to an even greater familiarity with the mysteries of golf, more than a few of us will miss his phone or more recently email, always with a "good morning or afternoon" before diving into always centered treatment of the matter at hand.

Glen Grady, CEO of Memorial Medical Center in Neillsville with almost 30 years in Wisconsin healthcare was honored at the Annual WHA Convention with a special Lifetime Achievement Award. Glen's energy and incredible sense of humor sometimes led folks to miss his incredible and usually dead-on observations about rural health in Wisconsin. He has managed a great leadership transition, but he will be missed.

rhcw.org
URAL HEALTH CAREER
WISCONSIN

Rural WISC Leadership Opportunity

The Wisconsin Rural Leadership Program is seeking candidates who want to actively participate in a unique opportunity to increase their knowledge, their skills and expose them to a broad range of issues, information, contacts and experiences that will make them better leaders. For more information go to **http://www.uwex.edu/ces/wrlp/**

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