

Review & Commentary on Health Policy Issues for a Rural Perspective – August 1<sup>st</sup>, 2012

## NRHA Pushes Back Against Medicare Myths

From “Rural Healthcare Advocates Rip MedPAC’s Claims on Access, Reimbursement” by John Commins, for *HealthLeaders Media*, 6/27/12:

“Advocates for rural healthcare are objecting to a Medicare Payment Advisory Commission report released in June that says that access to rural healthcare services is ‘similar’ to access in urban areas and that reimbursement for that care is ‘adequate.’ ”

“ ‘MedPAC’s report simply doesn’t match reality,’ Lance Keilers, CEO of Ballinger (TX) Hospital and 2012 National Rural Healthcare Association (NRHA) president, said in a media release. ‘This report lacks validity. It’s not what I see every day in rural America.’ ”

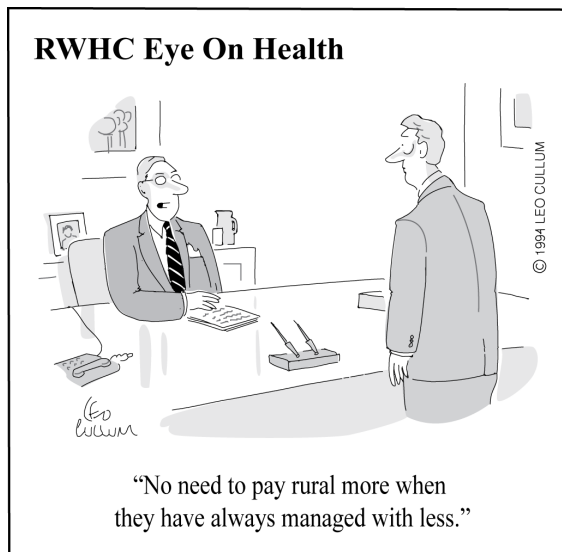
“Maggie Elehwany, NRHA’s government affairs and policy vice president, says the MedPAC report to Congress waves two red flags in the faces of rural providers.”

“ ‘The first is the assertion that access to care really is no longer a crisis in rural America. MedPAC for the first time ever made that inference and we take strong objection to that,’ Elehwany tells *HealthLeaders Media*. ‘In the rural counties in this country 77% are considered health professional shortage areas. For much of America just making their way to a physician still remains a challenge.’ ”

“We don’t stop playing because we grow old; we grow old because we stop playing.” - George Bernard Shaw  
RWHC Eye On Health, 7/10/12

“Elehwany says MedPAC contradicts itself on its claims of access. ‘MedPAC says based on their interviews with different beneficiaries and some of their data, that because the number of encounters that a senior beneficiary has with a provider is relatively similar between a rural and an urban area, then that must not be an access problem,’ she says.”

“ ‘But in the following sentence they state the reason that this is fairly similar is because rural patients have to travel to urban centers. To us that is so frustrating. That is the definition of an access problem if you are forced to travel to urban areas to get healthcare.’ ”



“The second red flag flaps at MedPAC’s suggestion that reimbursements to rural providers are on par with urban providers, if not better. Rural providers interpret those comments as a threat to the status of the 200 or so Medicare Designated Hospitals in this country with 100 beds or fewer that get a slightly higher reimbursement because 60% or more of their patients are Medicare beneficiaries.”

“In letters this week to the chairs and ranking members of the House and Senate ‘money committees’ 23 advocacy groups, including NRHA and 11 state hospital associations, call for the extension of the Medicare Dependent Hospital designation, which will expire on Oct. 1 if Congress fails to act.”

“In addition, the letter warns that ‘hundreds more rural facilities will be severely harmed due to the October 1 expiration of the rural current ‘low-volume adjustment’ for rural hospitals that incur higher incre-

“In addition, the letter warns that ‘hundreds more rural facilities will be severely harmed due to the October 1 expiration of the rural current ‘low-volume adjustment’ for rural hospitals that incur higher incre-

mental Medicare costs due to a low-volume of Medicare patients.’ ”

“ ‘When Congress shifted to the prospective payment system years ago, hundreds of rural hospitals closed. The system did not work for them,’ Elehwany says. ‘Congress intervened because rural patients were losing critical access points for healthcare. They created special hospital designations and they worked.’ ”

“Elehwany says it’s important to remember that seniors in rural areas are quite vulnerable. ‘They are poor and have a higher percentage of chronic diseases than their urban counterparts and they are overall a sicker population,’ she says. ‘So these hospitals are treating these vulnerable individuals and no facility makes money on Medicare reimbursements. It’s not like Costco where you can make up for it because you have this huge volume of other patients you are treating.’ ”

“Elehwany believes that MedPAC’s analysis is short-sighted and incomplete. ‘When MedPAC says these rural payments aren’t specifically targeted, or some are doing better than urban hospitals they don’t do the math and take the next step and figure out what would happen to these small rural hospitals if they lost these payments,’ she says. ‘We believe these hospitals will be forced to limit services and cut staff and some will have to close their door.’ ”

**Eye On Health** is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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“Also, Elehwany says rural hospitals face still another threat to Medicare reimbursements if the 2% cuts mandated by sequestration take effect in January. Averting those cuts would also require election-year action from a gridlocked Congress.”

“ ‘That 2% across-the-board cut through sequestration disproportionately harms rural providers,’ Elehwany says. ‘A large urban facility with a \$200 million budget can probably find ways to tighten their belt and cut 2% somewhere. If you’re a small rural hospital with maybe a \$5 million budget, 2% is a very significant margin, which means you will probably have to cut services. More than 40% of rural hospitals are already operating in the red. Further cuts to Medicare may put some of those over and cause doors to close.’ ”

“Rural healthcare advocates understand the powerful constituent clout that rural hospitals carry with each member of Congress. Senators and Congressmen don’t want hospitals in their districts to close because it represents a trifecta of negativity; lost jobs, lost economic activity, and lost access to healthcare.”

“With that in mind rural healthcare advocates are urging anyone who cares about the topic to head to Capitol Hill on July 30-31 to make their concerns known to their member of Congress. ‘Let them know how important these payments are, what they mean to keeping the doors in these rural hospitals in their districts open,’ Elehwany says.”

“The event comes immediately before the August recess and Elehwany says rural health advocates should use the face time at the Capitol to invite their respective members of Congress to the hospitals in their home districts ‘and show them the great work they are doing, show them the patients they treat and the narrow financial margins they are working under.’ ”

“Even with the gridlock made worse during an election year, Elehwany believes that rural hospitals can make a strong and bipartisan argument for self preservation. ‘The climate on Capitol Hill is very different this year,’ she says. ‘Every program has to be justified and we are fine with that. We feel we can do that.’ And despite the feisty rhetoric Elehwany says rural healthcare providers have no desire to pick a fight with MedPAC.”

“ ‘We are trying to tell Congress that this report is incomplete,’ she says. **‘The rest of the story is that rural hospitals may be doing a little better than the days when everybody was closing but if you took those Medicare payments away and took that MDH status away we are going to go back to those days. We believe the program created by Congress is doing exactly what it was intended to do, which is keep these hospital doors open.’**”

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## Closure of Sole Rural Hospital = 4% Tax

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From: “The Effect of Rural Hospital Closures on Community Economic Health” by George Holmes, Rebecca Slifkin, Randy Randolph, and Stephanie Pooley from *Health Services Research*, April, 2006:

**Principal Findings**—“Results indicate that the closure of the sole hospital in the community reduces per-capita income by \$703 or 4 percent and increases the unemployment rate by 1.6 percentage points.”

**Conclusions**—“The local economic effects of a hospital closure should be considered when regulations that affect hospitals’ financial well-being are designed or changed.”

“Hospitals are generally considered to be the locus of rural health care systems. Not only are important health services based at hospitals, but many of a community’s health care personnel are either directly employed by or supported by the local hospital. Further, hospitals are often considered vital to local economies as they bring outside dollars into the communities via third-party payors, provide jobs, stimulate local purchasing, and help attract industry and retirees.”

“As such, the closure of a hospital can have detrimental effects on a rural community. The rapid succession of hospital closures throughout the 1980s and 1990s helped stimulate legislation, such as creation of Critical Access Hospitals (hospitals that accept certain restrictions and are reimbursed 101 percent of cost from Medicare), designed to ensure the financial viability of small rural hospitals.”

“The effect of hospital closures on the health of community members has been relatively well documented and is not the focus of this study. Rather, we are concerned with the relationship between a hospital closure and the local economic conditions before and after the closure. In general, hospital closure is perceived to have negative economic effects on a rural community, although few studies have directly measured the effect.”

“In this paper, we estimate the effect of hospital closure on the local economy using multivariate regression methods that do not require the use of a control group consisting of communities not experiencing a hospital closure. We posit that the closure of a hospital negatively affects the economic health of a community, and we extend the hospital closure literature in two new dimensions. First, we differentiate between the impact of a hospital closure in a community where another hospital remains open and closure in a community with no other proximal access to hospital services.”

“This distinction is important because many of the ways that a closure can affect local economies, such as the amenity effect, can be mitigated by the presence of a near-by alternative hospital. Second, our analysis considers whether the economic conditions in communities where a hospital has closed can be attributed to the closure, or whether poor economic conditions preceded (and perhaps contributed to) the closure. Our methodology allows this assessment without the necessity of identifying appropriate controls, a difficult task as there may be intrinsic differences between financially struggling communities where hospitals ultimately close and those where they remain open.”

**Conclusion and Policy Implications**—“Although we find that a hospital closure per se does not negatively affect the long-run economic health of a community, losing the sole hospital in the county results in a considerable negative effect on the economy. Although there are no guarantees that it is the hospital closure per se that led to the economic decline of the county, our estimates reconcile with previous work and seem reasonable.”

“The results presented here suggest that the closure of a rural county’s sole hospital decreases the economic well-being of the community and likely places the lo-

cal economy in a downward cycle that may be very difficult to recover from. This effect was not only statistically significant but policy significant as well. The finding that the economic impact is an issue in communities where the sole hospital closed, an event that would almost always occur in rural areas, suggests important considerations for policy makers involved with hospital regulation. The traditional charge of health care regulators has been to increase economic efficiency, which places a particularly acute financial pressure on small rural hospitals. Because of low volumes it is difficult for these facilities to manage profitability under fixed reimbursement systems such as Medicare's PPS, as they experience significantly greater variability in inpatient demand across years, with a resultant instability in average costs per discharge."

"Thus, regulations imposed to increase hospital efficiency may have spillover effects; the economy is affected if the regulations induce the hospital to close. These economic effects, of course, compound any negative effects on health and health care access in rural communities because of the closure. Assessments of the impact of hospital closure have found that closures have created barriers to receipt of crucial emergency services, increased travel time to inpatient care with substantial effect on outcomes in the case of certain clinical conditions, and resulted in decreased utilization and a loss of access to a proximate source of primary health care. Combined with the decrease in physician supply because of hospital closure and the economic downturn demonstrated in this paper, access to primary health care would likely continue to decrease."

"Clinical decisions should, as far as possible, be evidence based. So runs the current clinical dogma. We are urged to lump all the relevant randomized controlled trials into one giant meta-analysis and come out with a combined odds ratio for all decisions. Physicians, surgeons, nurses are doing it; soon even the

lawyers will be using evidence based practice. But what if there is no evidence on which to base a clinical decision?"

"We, two humble clinicians ever ready for advice and guidance, asked our colleagues what they would do if faced with a clinical problem for which there are no randomized controlled trials and no good evi-

dence. We found ourselves faced with several personality based opinions, as would be expected in a teaching hospital. The personalities transcend the disciplines, with the exception of surgery, in which discipline transcends personality. We categorized their replies, on the basis of no evidence whatsoever."

**Eminence based medicine**—"The more senior the colleague, the less importance he or she placed on the need for anything as mundane as evidence Experience, it seems, is worth any amount of evidence. These colleagues have a touching faith in clinical experience, which has been defined as 'making the same mistakes with increasing confidence over an impressive number of years.' The eminent physician's white hair and balding pate are called the 'halo' effect."

**Vehemence based medicine**—"The substitution of volume for evidence is an effective technique for brow beating your more timorous colleagues and for convincing relatives of your ability."

**Eloquence based medicine**—"The year round suntan, carnation in the button hole, silk tie, Armani suit, and tongue should all be equally smooth Sartorial ele-




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## Alternatives to Evidence-Based Medicine

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From "Seven Alternatives to Evidence-Based Medicine" by David Isaacs and Dominic Fitzgerald in the *British Medical Journal*, 12/18/99:

gance and verbal eloquence are powerful substitutes for evidence.”

**Providence based medicine**—“If the caring practitioner has no idea of what to do next, the decision may be best left in the hands of the Almighty. Too many clinicians, unfortunately, are unable to resist giving God a hand with the decision making.”

**Diffidence based medicine**—“Some doctors see a problem and look for an answer. Others merely see a problem. The diffident doctor may do nothing from a sense of despair. This, of course, may be better than doing something merely because it hurts the doctor’s pride to do nothing.”

**Nervousness based medicine**—“Fear of litigation is a powerful stimulus to over-investigation and over-treatment. In an atmosphere of litigation phobia, the only bad test is the test you didn’t think of ordering.”

**Confidence based medicine**—“Restricted to surgeons.”

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## Population Medicine Leads to Population Health

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From “Is Population Medicine Population Health?” by David A. Kindig, MD, PhD, at his blog at [www.improvingpopulationhealth.org/](http://www.improvingpopulationhealth.org/) on 6/13/12:

“Terminology can be tricky; a word or phrase can sometimes mean different things to different people. This is currently the case with both population medicine and population health.”

“On this blog we have been explicit in our definition of population health, from the 2003 article I wrote with Greg Stoddart: ‘the health outcomes of a group of individuals, including the distribution of such outcomes within the group.’ Population

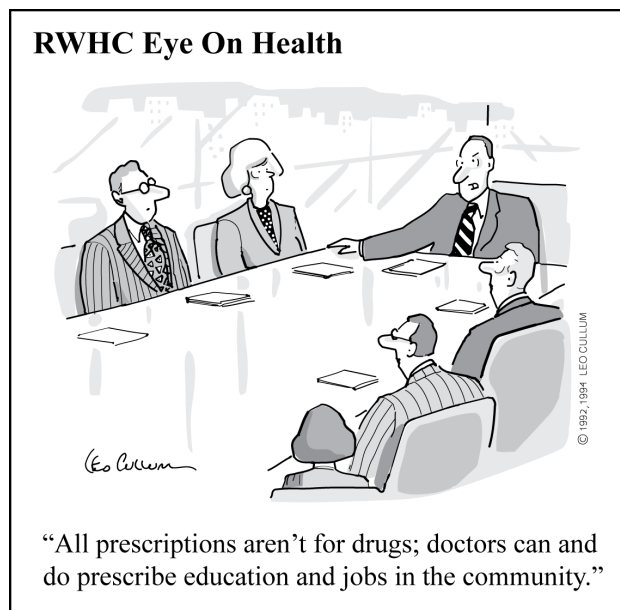
health also encompasses the multiple determinants of health that produce these outcomes.”

“The term population medicine has recently come into use. I was privileged to spend a few days last month in the Harvard Pilgrim Department of Population Medicine where our agenda included discussion of these definitions. They have defined population medicine as ‘...the specific activities of the medical care system that, by themselves or in collaboration with partners, promote population health beyond the goals of care of the individuals treated.’ Much of the discussion centered on how a health care organization, whose day-to-day work is closely tied to clinical practice, can also take action on the broader determinants of health. I think their definition gets it right. Population medicine is primarily concerned with clinical or health care determinants of health, but acknowledges the vital role of multi-sector partnerships (such as with public health, education, business, and social services) to influence health more broadly.”

“A colleague in Minnesota has taken this idea a bit further. As a part of the 2014 strategic planning process at HealthPartners in Minneapolis/St.Paul, George Isham worked with staff and board members to identify and commit to those traditional responsibilities over which the organization has influence or control (i.e., healthcare and health behavior). But they are also seeking other opportunities aligned with their mission for which they (as a health care organization) have limited opportunity for direct influence. They are therefore developing partnerships with

others to expand the scope of their influence beyond clinical care and health behaviors to the socioeconomic factors and the physical environment. Specific three-year goals were set for these partnership activities in the same way as was done for the traditional health care cost and quality goals of the organization.”

“Occasionally I hear population health being used to describe the clinical, often chronic disease, outcomes of patients



enrolled in a given health plan. Certainly an enrolled patient group can be thought of and managed as a population, but defining population health in terms of patient populations undermines our goal of emphasizing the critical role that non-clinical factors such as education and income play in producing health. Such a view is even more limiting than population medicine, and certainly is not appropriately termed population health from a modern policy framework.”

“In a recent and very thoughtful policy paper for the National Quality Forum Jacobson and Teutsch address these issues and recommend that ‘current use of the abbreviated phrase population health should be abandoned and replaced by the phrase total population health.’ They state that ‘this will avoid confusion as the clinical care system moves rather swiftly toward measuring the health of the subpopulations they serve. Geopolitical areas rather than simply geographic areas are recommended when measuring total population health since funding decisions and regulations are inherently political in nature.’ ”

“I think we should use the term population medicine to describe and promote efforts by leading clinical organizations to use their professional and financial base to actively participate and partner in improving total population health through a multi-

#### **Men’s Health Issues Added to the Rural Assistance Center**

The Rural Assistance Center’s newest Topic Guide features information, resources, and frequently asked questions related to men’s health in rural communities:

[www.raonline.org/topics/public\\_health/menshealth.php](http://www.raonline.org/topics/public_health/menshealth.php)

“Statistically-speaking, men face a wide range of unique health challenges. In addition to male-specific conditions such as prostate and testicular cancer, men are more likely than women to be hospitalized for congestive heart failure, diabetes, and pneumonia. They are injured and killed in accidents at higher rates overall, and have a lower life expectancy than women do.”

“In many rural areas, traditional definitions of masculinity may stigmatize health care, equating preventative services and other recommended screenings with weakness. This stigma is compounded by the relative dearth of research and information focused on men’s health in the United States—rural men’s health in particular.”

“This guide collects freely-accessible and reliable resources focused on all aspects of men’s health, emphasizing rural men’s health whenever possible.”

sectoral approach to address broad health outcomes and disparity reductions.”

*David A. Kindig, MD, PhD, is Emeritus Professor of Population Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.*

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## Water Quality in Rural Communities?

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*The \$2,500 RWHC Monato Essay Prize is offered each year to University of Wisconsin students or recent graduates. Submissions are due by April 15th. More information is available at [www.RWHC.com](http://www.RWHC.com)*

The 20<sup>th</sup> Annual Monato Essay Prize has just been awarded to Andrea Kremsreiter for her paper: “Agriculture’s Impact on Water Quality in Rural Communities.” The essay is at <http://ow.ly/c6Kqj>

Andrea grew up in Harshaw, one of Wisconsin’s many rural communities. Her family has a small farm where they raise a few cows and horses. Growing up in the beautiful Northwoods fostered her love of the outdoors and hockey. When she is not busy with work or her studies, she loves to bike, play volleyball, kayak or lace up her ice skates for a game of pick up hockey.

Currently, she lives in Madison where she recently graduated from UW-Madison with a degree in Medical Microbiology and Immunology and a certificate in African Studies. Upon gaining more direct patient care experience and finishing up some prerequisite courses this fall, she will begin applying to physician assistant programs.

Andrea intends to work as a physician assistant in a rural community in northern Wisconsin. She also had a strong interest in public health and really looks forward to working with patients, other healthcare members, and community leaders to develop initiatives to improve the health of the entire community.

Andrea was drawn to the topic of agriculture and rural water quality for several reasons: “The effects of factory farming have been mentioned several times in

my microbiology classes, although those points focused on how increased antibiotic use in feed lots, mass production technology, and even the diets of feed animals have contributed to the emergence of disease (E. coli, salmonellosis, etc).”

“Additionally, in a class dedicated to public health challenges of rural and urban communities, we discussed cases of environmental injustice imposed by concentrated animal feeding operations. Intrigued, I began researching how the shift to industrialized agriculture impacted the rural communities. Of course, the impacts of factory farms extend far beyond water quality and can threaten air quality, local economies, and the social cohesiveness of the community.”

“However, I decided to delve into the specifics of water quality because contamination is capable of negatively affecting entire communities and the generations to come. It is essential that actions be taken to prevent water pollution before it is too late. Having grown up drinking from my families private well, it was easy for me to empathize what a burden it would be to seek an alternative source should our water be contaminated.”

“As more research is done on the topic agricultural impacts on rural water quality, I sincerely hope that communities, businesses, and legislators acknowledge the importance of this topic and work together to achieve improved water quality and improved health.”

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## Ambiguity—Seeing it Clearly

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The following is from the June issue of RWHC’s *Leadership Insights* newsletter by Jo Anne Preston. Back issues are available at:

[www.RWHC.com/News/RWHCLeadershipNewsletter.aspx](http://www.RWHC.com/News/RWHCLeadershipNewsletter.aspx)

“**Leadership tip: get more comfortable with ambiguity.** Sit down and have a cozy cup of coffee with it, snuggle up and be friends. It’s either that or let ambiguity—a sense of uncertainty—raise your anxiety or turn you into a control freak, interfering with your success. When you put in an IV, run a lab test, type a

dictation, you know when you are done. Much of a technical role is unambiguous and thus satisfying to complete. In leadership roles, though, when you are coaching employees, improving the culture in your department, or becoming a more effective communicator—you never feel done. Confidence can slip because the clear markers of daily achievement have changed. This leads to a couple of traps:

1) The trap of continuing to do the job from which you were promoted. It’s more comfortable and makes us feel competent, but we miss delegation opportunities and we have less time to do leadership tasks.

2) Ambiguity overwhelms us and we either micromanage minutia to regain a sense of control or we start to spin mentally and the result is kind of a mess. Both over-controlling and spinning eat up a lot of energy and time. We get behind on the important things, and it becomes a vicious cycle.”

“John Kotter, Professor at Harvard Business School and acclaimed author of numerous books on change, suggests that about 90% of what we do as leaders is ambiguous. If we want to have a sense of achievement and confidence at the end of our workdays, we have to redefine our satisfiers and learn to function well with some level of uncertainty. Here are a few things that can help you do that:

- **Control Consciously**—Ask yourself what you do and don’t have control over. For the things you don’t have control over (i.e., other people, decisions beyond your scope, the future), decide what you can and want to influence. Focus your efforts into what you can control (your own attitude, behavior, approach)—all things which will help you with that influence.
- **Break Down your ‘Biggie’ List**—If for example, you are working to improve the culture in your department, today’s list might be: ‘pull out culture survey scores and select two key markers to focus on.’ Tomorrow’s list: ‘spend 5 minutes writing down specific behaviors that would demonstrate those key markers.’ Each of the next three days: ‘find one person in the department to recognize for those positive behaviors.’ Breaking the big things down into daily tasks keeps your internal ‘over-

whelmer' at bay (this is a good time management technique as well); plus you will see progress toward the larger goal.



states, 'In science it's not what you know; it's what you are willing to know you don't know.' Remember, most people don't get fired for stepping up to the plate to try to improve things, even if it doesn't go as planned.

- **Be a Pioneer**—Our brains love auto pilot so we drive to work the same way, eat the same foods, run our meetings the same, etc. Habits can be good things, but one way to expand our openness to the unknown is to change it up. Even little changes help because they maintain our awareness that not knowing is not fatal. Pioneers venture where there are no paths. While sometimes you'll end up on a dead end trail, new territory is also where discoveries are made.
- **Take Risks**—We'd all perform perfectly if we had 100% of the data and skill for the task at hand. A truer test of a leader is willingness to be innovative when you don't have 100%. If you are a perfectionist or have a tough time with corrective coaching or mistakes, practice making small decisions without having all the data you would like. Jon Kabat-Zinn, Professor of Medicine Emeritus and founding director of the Stress Reduction Clinic and the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School,

- **Practice mindfulness**—When I asked my husband how he deals with ambiguity, he said, 'I just focus on what is right in front of me; is that bad?' I teased him and said you could call that denial, or you could look at it as mindfulness—being fully present in the moment instead of worrying about the future."

"We are certain to have uncertainty; managing it skillfully is like learning to let go of one trapeze bar and making the most of the moment before you catch the next one."

*Contact Jo Anne Preston for individual or group coaching at [jpreston@rwhc.com](mailto:jpreston@rwhc.com) or 608-644-3261. For Info re the RWHC Leadership Series 2011-2012 go to [www.rwhc.com](http://www.rwhc.com) and click on "Services" or contact RWHC Education Coordinator Carrie Ballweg at [cballweg@rwhc.com](mailto:cballweg@rwhc.com) or 608-643-2343.*

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