Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – October 1st, 2005

Rural Advocates Mustn't Become Complacent

The Medicare Modernization Act (MMA) of 2003, was arguably the most important single federal policy advance for rural health since the rural health community became aware of itself as a unique field or constituency. This year has been a different story. The rural health community, and especially Critical Access Hospitals, have had to divert substantial energy from getting real work done at home, to play major league defense in Washington, DC.

While there are undoubtedly other contenders for the ***Almost Worst Rural Health Federal Policy of 2005 Award***, these four would win many votes:

☑ **First Draft of June MedPAC Report**

☑ **Launch of "Hospital Compare" Web Site**

☑ **Proposed Rural Hospital Building Ban**

☑ **House Version of 2006 Appropriations Bill**

"Almost" because the worst aspects of the first three proposed policies were averted, through the hard work of many people, working together on behalf of rural health, from rural and urban communities, from inside and out of our Nation's capital. This article will "name names," an inherently dangerous approach; forgiveness is asked of those not mentioned. Lists like this are always woefully incomplete.

The good news is that rural health prevailed in the face of three major attacks and the bad news is that our work is not finished. We still face major uncertainty around the 2006 Appropriations Bill and the House version that slashes or eliminates a host of core rural health programs. Hopefully, the Joint Conference Committee will use the Senate version. In either case, rural advocates have an ongoing challenge—an attitude in parts of Washington, particularly within the Centers for Medicare and Medicaid (CMS), that is at best, ill informed, about rural health and the reality of improving health and health care in rural communities.

Medicare Payment Advisory Commission Report—The federal Critical Access Hospital (CAH) designation describes the primary payment methodology for acute medical hospitals located in rural communities, over 1,100 as of June. The Medicare Payment Advisory Commission (MedPAC) is a highly influential advisory commission to Congress. The initial draft of the June MedPAC report was an incredibly inaccurate review of the program, with recommendations that were widely seen as down right hostile. Congress intended this program to end two decades of failed attempts to retro-fit to rural the Medicare payment methodology designed for large urban hospitals, the "Prospective Payment System." Unfortunately, this draft chose to frame CAH designation as an act of Federal charity, and that recipient communities had to prove their worth as "deserving poor."

The pushback from Commissioners with expertise in rural health was substantial and effective, in particular then Commissioners Mary Wakefield, Ray Stowers, Nick Wolter; in addition, Alan Morgan at the National Rural Health Association (NRHA), John Sheehan at BKD Health Care Group and Keith Mueller at the University of Nebraska provided invaluable technical support. At the April meeting it was clear that MedPAC staff got the message and the discussion fo-

cused on specific issues needing refinement, as true with any major program, opposed to the original wholesale attack on the underlying infrastructure.

Rural Hospital Building Ban—Supporters of rural health across the country actively opposed a CMS proposal to effectively institute a construction ban on the majority of rural hospitals, those designated as CAHs. The practical threat of the proposed regulation was enormous, transferring to CMS control over the basic structure of rural health care, a loss of local control never before seen.

Many rural hospitals are located on a small campus in the middle of residential neighborhoods with relocation being the most appropriate and sometimes only alternative when a facility needs to be rebuilt. Ironically, the CMS proposal to ban a local community's ability to build would have cost Medicare over time, more, not less—the higher labor costs of operating in an outdated or renovated building more than offsetting the slightly higher cost of new construction.

The proposed ban was an over reaction against a potential problem that now will be managed by the portion of CMS's proposed rule that appropriately survived, to require assurance that after the construction, a CAH would be servicing the same community and will be operating essentially the same services with essentially the same staff.

The CMS ban was based on the misguided belief, not tested in law and a break with CMS's past policy, that the relocation of a CAH should be treated differently than any other hospital.

While Wisconsin's Congressional delegation is consistently active in support of rural health, specific thanks on this issue go to Congressman Ron Kind from Western Wisconsin who was among the first nationally to strongly speak out and then work hard to defeat the proposed Ban.

RWHC Eye On Health

"It'd be easier to trust Washington if they sometimes returned the favor."

As noted by the Wisconsin Hospital Association's President Steve Brenton in its July 1st *The Valued Voice,* "Congressman Kind (D-Wisc) was successful in obtaining key support from House Ways and Means Committee leaders who agreed to intercede with CMS. The development occurred after Kind proposed an amendment that would have blocked the new CMS regulation. Congressman Kind withdrew his amendment, which had bipartisan support, only after Ways and Means Chairman Bill Thomas (R-Calif.) and Vice Chairwoman Nancy Johnson (R-Conn.) agreed to intervene directly with CMS leadership.)" In this fight, Ron Kind was notably joined in the Midwest by Wisconsin Congressman Paul Ryan and just across the Mississippi, Iowa Congressman Jim Nussle.

"Hospital Compare" Web Site—Last spring CMS announced it was rolling out the new Hospital Compare web site on April 1st. Unfortunately, this was no April Fool's Day joke. Given the bits and pieces that have been shared by the Hospital Compare developers before the launch, it became clear that this initiative, while well intended, was deeply flawed.

Rural advocates believe that rural communities deserve and demand the same high quality as all Americans. They saw at once saw that "Hospital Compare" was not designed for rural patients and communities. The web site separated out into a second class over 1,100 CAHs, those that serve most of rural America. The web site "said" that these hospitals were not "real" hospitals.

The labeling of the two groups made a bad situation worse. The first group of hospitals was called mainstream "acute care general hospitals" and the second "small rural, remote hospitals"—less than "acute care general." (In the heat of that moment, some suggested changing the first label to "overlarge urban, too bunched-together hospitals.") Hospitals with statistically small numbers in any particular category were

branded with a red yield sign as in, "you probably don't want to go there."

The real policy issue was not just about web sites or labels or misdirecting Medicare beneficiaries. It was also about the power of the language we use. The descriptive language that healthcare leaders accept from government, from payers or any other major sector begins to define what hospitals are and what they can become. The threat to how rural hospitals were to be seen and treated in future years was substantial.

While the operative word in Hospital Compare is "compare," the separating out of hospitals serving rural communities significantly impaired the use of the site by rural consumers. This blind spot was not a surprise as it was discovered that the "consumer focus" group that led to this decision had few to no rural participants and was held in Maryland, a state with no CAHs.

Contrary to the position taken by CMS, "Hospitals in rural communities are 'acute care hospitals' even when they may have lower volumes, may not offer all specialty services, and may not be paid through the 'Prospective Payment System.' A hospital does not need to do brain surgery or heart transplants to be a hospital; it needs to address the medical and health needs of its community in the most appropriate manner, and that is the mission of most rural hospitals." ("Reporting of Hospital Quality in Rural Communities: an Initial Set of Key Issues," adopted by the NRHA Policy Board, 5/20/05).

The **Rural Wisconsin Health Cooperative**, begun in 1979, is 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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Wisconsin Senator Russ Feingold communicated his concerns to CMS Administrator Dr. Mark McClellan nearly two weeks before the web site went public on April 1st with his concern "that leaving smaller, rural hospitals in a separate subsection sends a message that hospitals serving rural communities are not hospitals and are in fact something less." Through the intervention of the Wisconsin Hospital Association and others, Nancy Foster, Senior Associate Director of Health Policy at the American Hospital Association, was able to work with CMS to solve most but not all of the identified anti-rural problems.

2006 Appropriations Bill—From an NRHA Advisory containing the House Rural Health Care Coalition's letter to the Chair and Ranking Member of the House and Senate Appropriations Committee:

"As Members of the Rural Health Care Coalition (RHCC), we respectfully request your support during the Fiscal Year (FY) 2006 Departments of Labor, Health and Human Services and Education Appropriations Conference for critical rural health programs funded through the Health Resources and Services Administration (HRSA). These valuable HRSA programs work together to provide seed funding and support to rural health care providers, patients, and rural health services researchers."

"While we appreciate the proposed level of funding for rural initiatives such as Rural Hospital Flexibility Grants, we believe that the reduction or elimination of funding for the programs listed below would significantly damage delivery of health care services in rural areas. The RHCC is hopeful that conferees will move toward the funding levels recommended in the Senate-passed FY 06 Departments of Labor, Health and Human Services and Education Appropriations bill for these five HRSA-administered rural health programs."

Of absolute critical importance to rural advocacy is the following, as known at the time this was written:

> **Rural Health Research/Policy**
> *Senate proposed funding: $8,528,000*
> *House proposed funding: $0*

If the House version prevails, rural advocates and communities will lose the basic capacity to understand the ongoing evolution of the threats and oppor-

tunities faced by rural communities as we/they struggle to gain access to care and health status comparable to the country as a whole.

We will return to before the mid-1980's when basically there was little to no understanding of how private markets and government policy hurt or failed to help rural health care and rural communities. It was policy development by feeling around in the dark.

Bottom line: The loss of this funding will rip the guts out of the rural health policy development and communication capacity in the Federal Government, and for most of us in the field who lack any other means of financing rural relevant health policy research.

Our Future—Rural advocates have an ongoing challenge—an attitude in parts of Washington, and around the country, including within CMS, that is at best, ill informed, about rural health and the reality of improving health and health care in rural communities.

Rural advocates must not become complacent.

Big Ugly Rural Trends

From a Commentary, "Big Ugly Rural Trends" by Thomas D. Rowley, a Fellow at The Rural Policy Research Institute, 8/30/05:

"Every once in awhile, I'm asked to give a speech on rural issues. Flattered, I generally accept—despite the fact that for one who sits alone all day writing to nameless, faceless readers thousands of miles away, standing in front of a live audience within range of a well-aimed dinner roll is a frightening experience. Fortunately, the rolls didn't fly last week when I had the privilege of addressing a few hundred local officials in tiny Edna, Texas, courtesy of the Golden Crescent Regional Planning Commission. My topic: big ugly trends in rural affairs."

"Rural America today suffers an identity crisis. What is rural today? My answer is a mix—one part hip, one part hick, two parts misunderstood and three parts forgotten."

"In some parts of the country, rural living has become hip—if by rural living, you mean a 5,000 square foot retreat on the river close enough to a Starbucks for a daily cappuccino and the New York Times."

"But if by rural living, you mean something else—a small town where people live in modest houses and go to church, school, and work; where work is often just a job not a career; where lots of folks work hard and still are poor, have no health insurance and no retirement package—that's something else entirely. For some, that's not hip; that's hick. Something to be looked down upon. Indeed, it's been said that rural Americans are one of the last groups it's okay to ridicule."

"For others, rural living is something they simply don't understand because it's something they—including many policymakers—don't think much about, something they've forgotten."

"Lip service to rural America is increasing. Policymakers do think about rural America on two occasions: Farm Bills and elections, when lack of attention turns quickly into lip service."

"Every five years the Farm Bill is trotted out as the Nation's flagship rural policy, which purports to help all of rural America. Even though rural America is so much more than agriculture. (See identity crisis above.) And even though commodity programs get the

lion's share of funding. In the last Farm Bill, they got $18 billion. Rural development got $100 million."

"The other time policymakers pay homage to rural America is during election season. In 2004, Republicans locked up the rural vote by doing that. In preparation for the next election, Democrats are trying to woo that rural vote away. Yet between elections—whichever party wins—the rural promises fade quickly from the politicians' memories. Indeed, they forget so quickly that rather than help rural America, they appear bound and determined to harm it."

"Governmental devolution keeps on rolling. For rural communities with small overworked, often part-time staff and elected officials, the workload from federal and state government is out of hand. Before going to Edna, I spoke with the Gonzales County Judge David Bird and asked him what his big challenges were. At the top of his list: the responsibilities federal and state governments keep passing down to local governments…without passing down any more money to deal with them. The reporting requirements alone, he told me, are 'monumentally burdensome.' So burdensome, he said, that sometimes it's hard to see a reason to comply with all the rules and regulations knowing that you're not going to get anything in return."

"We've moved from governance to government. Over time, government in the United States has become increasingly specialized. At the same time and partly as a result of that, citizenship in its truest sense has become increasingly marginalized. In other words, governance—the process of making collective decisions that affect our communities—has gone from being a communal effort to being a contractual effort. That, in turn, has led to people who identify themselves more as mere taxpayers and less as citizens. People who see themselves as buying a service from government rather than participating in the act of governance. People who see government at best as an inefficient tool in need of becoming more business like and at worst as a not-so-necessary evil in need of downsizing. People who no longer see themselves as either part of the problem nor part of the solution."

"And that, I would argue, is the ugliest trend of all."

Strong Rural Communities Initiative Update

The following is from the September 9th meeting of Wisconsin's Rural Health Development Council:

"The Rural Health Development Council (RHDC) works to link rural health and community development, is appointed by the Governor, confirmed by the Senate, and staffed by the Wisconsin Office of Rural Health. Consequent to strategic planning sessions in early 2004, it began developing the Strong Rural Communities Initiative (SRCI)."

"The SRCI goals are to support Healthiest Wisconsin 2010 by implementing sustainable rural models for medical, public health, and business collaboration (system priority #3) and promoting preventive health best practices in rural Wisconsin (health priority #1). Through a statewide competitive process, it chose projects from six diverse communities in August, 2005. For three of the projects, SRCI is applying for a three-year implementation grant to the Wisconsin Partnership Fund for a Healthy Future at the University of Wisconsin (UW). SRCI is similarly applying to the Healthier Wisconsin Partnership Program at the Medical College of Wisconsin (MCW) to fund the other three projects."

"RHDC created the SRCI Steering Committee, composed of the Academic Partners for both applications along with a cross-section of rural health statewide leaders. Byron Crouse, MD, Associate Dean for Rural and Community Health, University of Wisconsin Medical School, will be the UW Academic Partner, with support from the Wisconsin Office of Rural Health (WORH). In addition, WORH in its role as staff of the Rural Health Development Council will provide general support to the SRCI. Syed Ahmed, MD, MPH, DrPH, Director, Center for Healthy Communities at MCW, will be Academic Partner with help from staff at the Center for Healthy Communities." The UW application cycle comes first and will include these three projects:

"**More ENERGY**, a successful Hayward area exercise and nutrition program proposes to expand throughout Sawyer County and build strong, sustainable collaborations between Hayward Memorial Hos-

Hospital and Hayward Clinic, the Sawyer County Public Health Department, and area businesses, tribal, and other community health partners. Intended to educate, motivate and facilitate changes in lifestyle to decrease the risk of cardiovascular disease in the county, Phase I will add evening hours to the current *More ENERGY* program and work with local food retailers and restaurants to promote healthy lifestyles. *More ENERGY at Work*, Phase II of the project, will engage the workforce throughout Sawyer County by offering cardiac risk profiles, safe workout and proper nutrition instruction, and on-site follow-up evaluations at area employers."

"**Jackson County Working for Wellness** will work with the Jackson County Community Health Network (JCCHN) to implement six worksite wellness programs in the county. Employers are critical to the success of this program, as they will work to promote local primary and preventive healthcare services in order to build a successful wellness program. By encouraging employees to modify poor nutrition and exercise behaviors, employers will become partners in improving the health of the population in Jackson County. An initial health risk assessment will combine data from screenings of blood pressure, cholesterol, glucose, lipid levels, risk factors, and family history. The worksite wellness program will include an 8-10 week session providing education and didactic learning opportunities and will work closely with the JCCHN, Black River Memorial Hospital, the Jackson County Health Department, and employers in Jackson County."

"**Sauk Prairie Fitness-Improvement-Teamwork (FIT) Program** will expand upon a successful pilot program with Sauk Prairie Police Department to improve nutrition/exercise on the police force, by engaging employees in other municipal and non-governmental local businesses. In recognition that prevention of lifestyle-related illness/disability cannot succeed unless the individual's effort in improving his/her health is supported by the family and the community, the *FIT* program will establish a community health coalition in an effort to reduce overall healthcare expenditures in the business community. A plan to improve the health and wellness status of the community will engage Sauk Prairie Memorial Hospital/Clinics, Prairie Clinic, Dean/St. Mary's Health Works, Villages of Sauk City and Prairie du Sac, Sauk Prairie School District, Sauk County Development Corporation, and Sauk Prairie Memorial Hospital Foundation."

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

Business Taking Up Population Health

From "Population Health Improvement-The Next Era of the Health Care Management Evolution" by Stephanie Pronk, *Benefits Quarterly*, 3rd Q, 2005:

"The trend of increasing health care costs over the past years shows no signs of slowing. While employers have attempted to address the issue with various cost-shifting and cost-sharing initiatives, those attempts have often fallen short. The management of employee health and productivity needs to move to a more encompassing organizational view that addresses the most expensive drivers of these costs head-on, with prevention, education and employee responsibility as key tenets. Organizations that implement programs to maintain, improve and manage their population's health, will enjoy substantial savings and enhanced employee productivity."

"The health care debate in this country is one of the most controversial issues of our generation. For employers struggling with the right approach to benefits and cost control, it's also one of the most important. In order to successfully facilitate health management, an organization must focus on the bigger picture: its employee population's overall health status."

"The fly in the ointment is this: While the health status of Americans is driving increases in all related health costs, by far the most dramatic factor determining health status is the behavior of individuals themselves. This, of course, recognizes that there are additional determinants of health beyond our control-factors that influence our risk to develop disease, our actually developing the disease and even whether we may die from the disease. Behavior patterns and environmental exposures determine whether and how our genes will be expressed. Our behavior choices are influenced by our social circumstances and our social circumstances affect the health care we receive. The fact remains, however, behavior determines up to 50% of health status and we can influence and change behavior to positively affect our health."

"Interestingly, in examining behavior, the worst offenders aren't necessarily what you'd expect. The impact of physical inactivity and obesity on health and health care costs has surpassed the negative impact of smoking, for instance, in terms of costs, poor health, increased development of disease and mortality. Given this situation, employers need more far reaching, yet targeted-proactive programs to beat health care costs before they hit."

"A Logical Approach—There is an alternative that can help companies avoid continued cost increases, manage liability and budget more effectively: population health improvement. Population health improvement is a cost-effective, comprehensive approach that maintains, improves and manages the overall health of a population by segmenting the population by health conditions and risks and targeting interventions to meet the needs of each individual. This approach is supported by seven major program components:

- Assessment/Education
- Disease Prevention
- Lifestyle Behavior Change
- Health Decision Support
- Disease Management
- Absence Management
- eHealth"

"After years of fine-tuning, trial-and-error implementation and research, it's now verifiable: well-designed and implemented health improvement and management programs can save more money than they cost individuals and organizations."

RWHC "HIT" Takes Major Step Forward

The Rural Wisconsin Health Cooperative has recruited a health information technology (HIT) director to spearhead the development of collaborative initiatives and provide HIT-related consulting services to member hospitals.

The new HIT director, Louis Wenzlow, previously served as the IT director at Reedsburg Area Medical Center where he successfully planned and implemented a wide range of HIT initiatives. His role at RWHC will focus consulting services in the areas of HIT planning, technology evaluation/acquisition, and project management. The HIT Director will not be involved with the actual implementation of hospital IT projects; that will still be the responsibility of the Members' internal IT staffs. However, he can play a facilitative role, bringing a fresh and experienced perspective to the following:

- Annual and long range HIT strategic planning
- HIT vendor selection
- HIPAA security rule consulting, including policy and procedure review and development
- HIT system-use documentation review and development
- Facility-specific HIT implementation and project management support

In addition to working with IT staff, leadership teams and department directors, the HIT director will constantly look for opportunities to align your HIT plan with the collaborative initiatives sponsored through RWHC, such as:

- Integrated Electronic Health Record (EHR)
- PACS
- Teleradiology and Telepharmacy Services
- Dictation/Voice Recognition
- Medical Practice Management and EMR

RWHC believes that rural providers and their patients deserve the same advanced technologies that are

available at large urban facilities and hospital systems. By pooling resources via a common data center, Members can utilize these technologies at an affordable cost. Just a few examples of the benefits of a shared HIT model include:

- Lower licensing costs
- Shared system administration and data center
- Shared staffing, helpdesk and training
- Ongoing purchasing and negotiating power
- Data exchange capabilities among providers

Louis Wenzlow can be reached at 608-643-2343 or lwenzlow@rwhc.com.

Other RWHC HIT Services

RWHC Wide Area Network & Data Center—Since 2002, RWHC supports a comprehensive fiber network and data center that offers scalable connectivity options ranging from partial T1 to 100mb lines. The system is managed and monitored 24-7, so it is very secure. A partial list of services include: T1 connectivity to regional providers, Internet access with web filtering, VPN integration with remote users, e-mail encryption with SPAM/virus filtering, and disk-to-disk offsite data protection.

Rural Wisconsin Technology Services (RWTS)—For network, server, voice, and technology infrastructure issues, RWHC has partnered with Digicorp, Inc., to form RWTS—a fully staffed professional organization that will meet your core network engineering needs. RWTS offers on-call technical support, hardware/software purchasing, short-term IT staffing, application development, and education/training.

Outsourcing IT Staff Through RWHC—RWHC is committed to the concept of providing value through the shared HIT model. As we move in the direction of a shared electronic health record, we are interested in developing a pool of IT professionals with specialized HIT skill-sets to work as full or part-time equivalents in member hospitals.

For additional information about these services, contact Darrell Statz at (608) 643-2343 or dstatz@rwhc.com.

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