

Catholic Association Speaks Up for Rural

The Catholic Health Association of the United States devoted their entire 2010 September-October issue of *Health Progress* to “Rural Health Care Extends—and Needs—a Hand.” *This in-depth look at rural health is available online at <http://www.chausa.org/>*

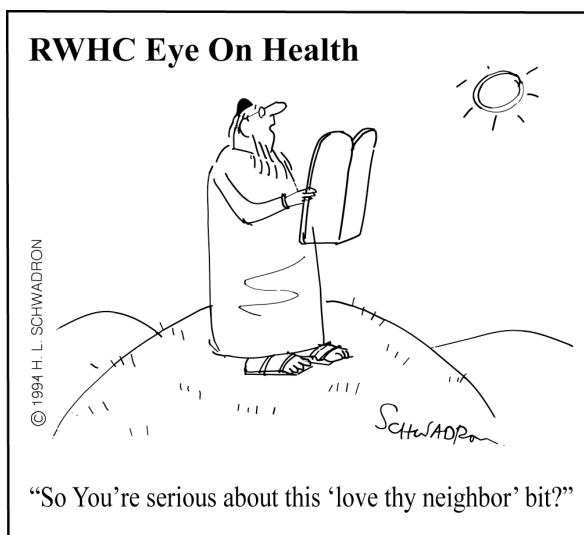
“Rural health care in America faces increasing challenges in delivering quality health care to the populations it serves—populations that often experience significant disparities in economic and health status in comparison to urban counterparts. Resources are strained, services often limited, and health professionals, particularly physicians, are in increasingly short supply. At the same time, new technologies, such as telemedicine, telepharmacy and even telepsychiatry are revitalizing rural health care by connecting patients and professionals with specialized urban health care centers. In this era of health reform, advocates can help ensure that rural health care gets its fair share of benefits.”

“The statistics are startling: 75 percent of the United States’ land mass is nonmetropolitan (rural) and home to 20 percent of the population. Yet that means 1 in every 5 Americans experiences significant disparities in health and health care delivery due to geographic isolation, socioeconomic status, health risk behaviors and limited job opportunities.”

“The right word may be effective, but no word was ever as effective as a rightly timed pause.” - Mark Twain
RWHC Eye On Health, 9/16/10

More rural health statistics in this issue include:

- Rural residents are less likely to have employer-based health care coverage or prescription drug coverage
- The rural poor are less likely to be covered by Medicaid benefits
- Rural adults are more likely to report having diabetes than are urban adults—with rates of diabetes markedly higher among rural American Indian and black adults
- Rural residents are more likely to be obese than those in urban communities
- Fewer than 10 percent of physicians practice in rural communities
- Rural women are less likely than urban women to be in compliance with mammogram screening guidelines or to have had a Pap smear done within the past three years
- Alcohol abuse is a significant problem among rural youth
- Suicide rates among rural males are higher than among men in urban areas
- In rural areas, the majority of emergency medical services first responders are volunteers



- One-third of all motor vehicle accidents occur in rural areas; two-thirds of all motor vehicle deaths occur on rural roads”

Below are highlights from a variety of the articles:

“Rural America: A Look Beyond the Images” by John A. Gale, M.S.: “The issues faced by patients and providers in rural health care differ greatly from those of urban counterparts. They also differ across rural communities. Understanding these differences, and the differences among rural populations across America, is critical to providing health services to rural Americans, who are often impeded by economic factors, cultural and social differences, educational shortcomings and isolation in their efforts to lead normal, healthy lives. The challenges provide opportunities for Catholic health care to make a difference in the lives and health of some of the nation’s most vulnerable citizens.”

“Rural Renaissance or Death Throes?” by Charles W. Fluharty, M.Div.: “A metropolitan focus of place-based investments ignores critical linkages with rural America, which includes three-fourths of the U.S. natural resource base and twenty percent of the population that stewards those national treasures. Advocates for place-based policy are engaged in a recalibration to ensure attention to the rural-urban continuum. Meanwhile, rural advocates are needed to ensure equity for rural populations.”

RWHC 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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Email office@rwhc.com with *subscribe* on the Subject line for a free e-subscription.

“How to Grow a Rural IT Network” by Paul Browne, M.S.H.A: “In summer of 2008, seven of Trinity Health’s critical access hospitals in northern Iowa successfully launched the nation’s first rural integrated electronic health-record network. While the process is not for the faint of heart—it involves standardizing systems, vendors and applications, and comes with financial and cultural challenges—Trinity’s experience can serve as a road map for other health systems.”

“Nurturing Work and Family Life in Rocky Rural Soil” by Clare Willrodt: “Avera Health, based in Sioux Falls, S.D., serves a 71,550-square-mile area with 975,000 residents and, according to the U.S. Census Bureau, has one of the nation’s lowest rates of physician-to-population rates. Avera has developed a program of effective recruitment and retention measures in which community involvement is key, as well as programs aimed at encouraging high-school-age youth to pursue careers in health-care-related fields.”

Smaller Rural Hospitals Face \$ Pressure

From “A Comparison of Rural Hospitals with Special Medicare Payment Provisions to Urban and Rural Hospitals Paid Under Prospective Payment,” by G. Mark Holmes, PhD, George H. Pink, PhD, Sarah A. Friedman, MSPH, and Hilda A. Howard, BS, at the North Carolina Rural Health Research & Policy Analysis Center and funded by the Federal Office of Rural Health Policy, 8/10:

“The financial performance of rural hospitals has long been a concern to federal and state agencies. Four specific Medicare hospital classifications, each with different payment enhancements and qualification criteria, are available to hospitals that serve rural communities [sole community hospital (SCH), Medicare-dependent hospital (MDH), rural referral center (RRC), and critical access hospital (CAH)].”

“The perceived benefits of conversion to CAH status have led to calls for expansion of cost-based reimbursement to other rural hospitals that are purported to be under financial pressure. However, the

financial performance and condition of these other rural hospitals have not been empirically assessed.”

“This study compares the financial performance and condition of rural hospitals with special Medicare payment provisions to urban and rural hospitals paid under prospective payment (U-PPS and R-PPS hospitals, respectively). Nine ratios from the three most common categories of ratios used in financial statement analysis (profitability, liquidity, and capital structure) as well as four other ratios that are commonly used to evaluate rural hospital financial performance are assessed.”

Five Principal Findings

- “There is variation in financial condition across types of rural hospitals. It is inaccurate to characterize all rural hospitals as being under financial pressure; rather it appears that some types have many hospitals under a lot of pressure (CAHs, MDHs and R-PPS hospitals), some have some hospitals under pressure (SCHs), and some have few hospitals under pressure (RRCs and RRC/SCHs). The hospitals under a lot of pressure should be of greater concern to policy makers and those concerned with access to hospital care by people in rural America.”
- “There were substantial differences between CAHs and other hospitals. On average, CAHs took longer to collect their receivables, received more of their revenue from outpatient business, and had lower levels of allowances and discounts. In terms of profitability, on average, CAHs, MDHs, and R-PPS hospitals were consistently less profitable than other hospital classifications. CAHs had the oldest fixed assets in two of three years. With older plant and equipment, CAHs may in the future have less ability to attract patients and retain physicians.”
- “RRCs appear to have performed well as a group. They had greater ability to pay obligations related to long-term debt, principal payments and interest expense. Probably the strongest finding of this study is the higher profitability of RRC/SCHs. These hospitals were better at controlling expenses relative to revenues, generating cash flow from providing patient care services, and avoiding financial distress from negative margins. These findings

are likely influenced by the fact that RRCs and RRC/SCHs are the largest type of rural hospital.”

- “Substantial differences in cash management exist among hospitals with different payment classifications. U-PPS hospitals may have greater opportunities for short-term investment of surplus cash, or a higher proportion of U-PPS hospitals may belong to a system. Many systems ‘sweep’ the cash accounts of their affiliated hospitals daily, so fewer dollars are left on hand, and the hospitals depend upon their corporate office for any short-term credit or liquidity needs.”
- “The profitability of all hospitals declined sharply in 2008. The profitability decline likely reflects the worsening economy and raises concern for the hospital industry as a whole. Even RRCs, the strongest performers as a group, appear to have substantially deteriorated financial positions in 2008. It will be important to monitor future rural hospital financial performance to gauge the effects of both the economy and health reform legislation.”

“The benefit of Medicare cost-based reimbursement for CAHs has led to calls for its expansion to other rural hospital classifications that are purported to be under financial pressure. However, this study has found that CAHs remain relatively less profitable, suggesting that Medicare cost-based reimbursement, while potentially improving Medicare revenues, should not be seen as a panacea for rural hospitals. (Note: this study did not specifically consider the potential effect of changes to reimbursement methods.)”

“The financial performance of CAHs relative to other hospital classifications suggests that low volumes, payment from other payers (private insurance, Medicaid, and self pay), and uncompensated care still have a substantial impact on the financial condition of these hospitals. Therefore, while extending Medicare cost-based reimbursement to other rural hospitals would likely result in financial benefit, the degree of improvement in financial condition to expect is uncertain.” The complete report is available via:

<http://www.ruralhealthresearch.org/>

HIT Meaningful Use: Six Strategic Questions

From “Meaningful Use: Six Strategic Questions Rural Hospitals Should be Asking” on Louis Wenzlow’s blog at <http://www.worh.org/hit/> :

“Under ARRA, in order for hospitals to access federal HIT (Health Information Technology) incentives and avoid future penalties they must become ‘meaningful users’ of electronic health records. Now that CMS has issued the final Stage 1 HIT incentive rule, all providers that are intent on participating in the incentive program should be engaged in an EHR planning and implementation process. Here are six key questions to be asking as part of that process:

1. Vendor Certification: Am I hitched to the right horse?
2. CPOE and Decision Support: Am I positioned for physician engagement?
3. How does ED inclusion impact my implementation strategy?
4. Am I ready for the QI measure (ER, VTE, and Stroke) data capture load?
5. For CAHs, how will I deal with the eligible EHR cost definition ambiguity?
6. When should I conduct a comprehensive security risk assessment?”

“Other questions simmering on Stage 2 backburner:

7. What is my strategy for evidence-based order sets?
8. Will I need to start coding at the point of care to enable robust decision support?
9. What tools (BI/dashboards) can I implement to manage clinical documentation and decision-making compliance?
10. How will I deal with the workflow issues relating to the summary care record exchange and medi-

cation reconciliation requirements (which are currently optional objectives, but which will likely be required in Stage 2)?”

Medicare Needs to Get Real on Telehealth

From “Medicare Change to ‘Privileging by Proxy’ Could Hurt Psychiatrists Providing Telepsychiatry” in *Psychiatric Times*, 9/1/10:

“Rural hospitals are concerned that a proposed change in Medicare policy will put a crimp in their use of psychiatrists via telemedicine. The Centers for Medicare and Medicaid Services (CMS) wants rural hospitals and critical access hospitals (CAHs) to take certain new steps to ensure that the private-office psychiatrists they connect to in big cities for telemedicine services are qualified for that purpose.”

“Deanna Larson, vice president, quality initiatives, Avera Health, said, ‘To provide psychiatry services to these rural areas, Avera must utilize psychiatrists affiliated with private practices across the US. Unfortunately, CMS’s proposed rule change does not alleviate the credentialing and privileging burden for our rural hospitals in this situation.’ Avera is a regional health care system with more than 90 clinics, hospitals, long-term-care facilities, and home health agencies in South Dakota, Iowa, Minnesota, and Nebraska.”

“Avera owns 24 CAHs in those states. CAHs are designated as such by the federal government and must be beyond 50 miles from the nearest other hospital and have fewer than 25 beds, among other qualifications. Larson said the primary care physicians at those CAHs need 3 times as many psychiatrists as they currently have access to in order to provide the behavioral health care services that are in demand. To meet that need, Avera has started to experiment with videotaping an initial behavioral consult between a patient and a psychologist and then paying a telepsychiatrist to view that videotape and make recommendations.”

“For a decade, psychiatrists have been providing services via telemedicine to seniors and have been reimbursed by Medicare for those services. The Medicare,

Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 passed in October 2001 expanded the list of approved Medicare telemedicine services to include consultations, office visits, and office psychiatry visits. Currently approved telemedicine services, for which Medicare reimburses include initial inpatient consultations, follow-up inpatient consultations, office or other outpatient visits, individual psychotherapy, pharmacological management, and psychiatric diagnostic interview examination.”

“Up until July 15, 2010, rural hospitals had been able to use psychiatrists for telemedicine without credentialing them; they relied on the psychiatrist’s credentialing at his or her home urban hospital. A congressional law passed in 2008 changed that, forcing Medicare to propose new telemedicine credentialing rules. The changes were proposed last May 26. Rural hospitals could continue to use the same psychiatrists for telemedicine they had been using. But the CAHs—and their satellite clinics—would have to ensure 4 conditions are met.”

“Those conditions are that (1) the big-city hospital that has already credentialed a psychiatrist is Medicare-participating; (2) the physician is privileged at the distant-site hospital; (3) the physician holds a license issued or recognized by the state in which the hospital whose patients are receiving the telemedicine services is located; and (4) the big-city hospital has evidence of an internal review of the physician’s performance and sends the rural hospital this information for use in its periodic appraisal of that physician. That internal review information would have to include all adverse events that may result from telemedicine services provided by the urban physician and also that all complaints the hospital has received about him or her.”

“Conditions 3 and 4 are causing the most concern. ‘While we expect that CMS viewed this as a reasonable and more efficient course for privileging, RWHC

[Rural Wisconsin Health Cooperative] believes this will have the contrary effect because requiring the exchange of the occurrence of adverse events and complaints relevant to the practitioner, along with signed attestations, will be burdensome and not forthcoming from distant site provider,’ said Tim Size, executive director, RWHC.”



tions where an out-of-state practitioner could be in compliance with a state’s licensing statutes but not ‘hold a license’ in that state,’ Sprang explained.”

It’s Now Official: America is “Obesogenic”

From <http://www.americashealthrankings.org/> :

“In the United States, the average male has added 17.1 pounds in the past 20 years and the average female has added 15.4 pounds. This weight gain has pushed obesity levels to record heights in the United States.”

Est. Prevalence of Obesity in the United States (Percent of Adult Population)

	Lower Estimate (Self-Reported)	Midpoint	Upper Estimate (Adjusted)
2008	26.50%	31.30%	36.00%
2013	31.70%	36.50%	41.20%
2018	38.00%	42.80%	47.50%

Wisconsin's Best & Worst Five Health Measures America's Health Rankings - 2009

Measure (Behavior, Disease, Environment, Policy or Outcome)	Rank
High School Graduation (Percent of incoming ninth graders) - B	1st
Immunization Coverage (Percent of children ages 19 to 35 months) - P	3
Stroke (Percent of adult population) - D	3
Lack of Health Insurance (Percent of population) - P	4
Occupational Fatalities (Deaths per 100,000 workers) - O	5
Geographic Disparity (Relative standard deviation) - O	29
Prevalence of Smoking (Percent of population) - B	32
Cardiac Heart Disease (Percent of adult population) - D	37
Prevalence of Binge Drinking (Percent of population) - B	50
Public Health Funding (Dollars per person) - P	50th

"If current trend continues, obesity will add nearly \$344 billion to the nation's annual health care costs by 2018. Obesity-related direct expenditures are expected to account for more than 21 percent of the nation's direct health care spending in 2018."

"So, obesity levels are most likely substantially higher than often quoted. Using this information, Dr. Thorpe projected expected obesity levels in 2013 and 2018 based upon self-reported data and adjusted these projections for likely under-reporting."

"Obesity is described as the fast-growing public health challenge the nation has ever faced - and its rapid increase has crossed all socio-economic groups. Obesity is attributable to inadequate activity, unhealthy eating habits and changing food alternatives."

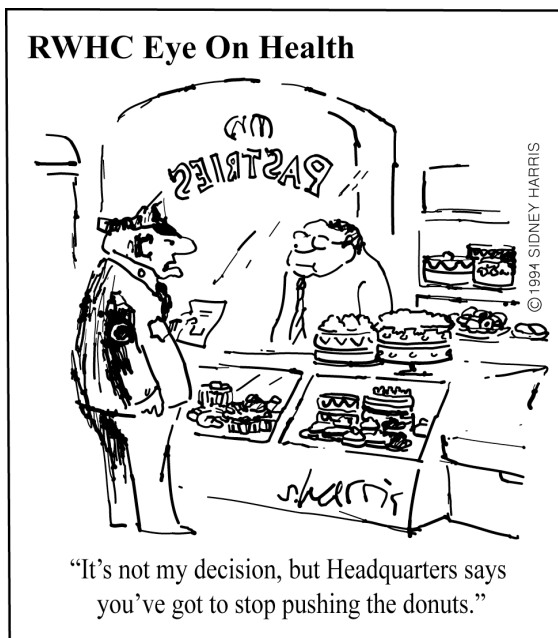
'American society has become 'obesogenic,' characterized by environments that promote increased food intake, non-healthy foods, and physical inactivity' according to The Centers for Disease Control and Prevention."

"In 2018, Colorado is projected to be the only state that will have a prevalence of adult obesity that is less than 30 percent. While Oklahoma, Mississippi, Maryland, Kentucky, Ohio and South Dakota will all have adult levels over 50 percent."

RWHC Social Networking:

The Rural Health Advocate: www.ruraladvocate.org/
Rural Health IT: www.worh.org/hit/

RWHC Eye On Health



Too Rare Collaboration Good for Researchers

From "Rare Sharing of Data Leads to Progress on Alzheimer's" by Gina Kolata in *The New York Times*, 8/12/10:

"In 2003, a group of scientists and executives from the National Institutes of Health, the Food and Drug Administration, the drug and medical-imaging industries, universities and non-

profit groups joined in a project that experts say had no precedent: a collaborative effort to find the biological markers that show the progression of Alzheimer's disease in the human brain."

"Now, the effort is bearing fruit with a wealth of recent scientific papers on the early diagnosis of Alzheimer's using methods like PET scans and tests of spinal fluid. More than 100 studies are under way to test drugs that might slow or stop the disease."

“The key to the Alzheimer’s project was an agreement as ambitious as its goal: not just to raise money, not just to do research on a vast scale, but also to share all the data, making every single finding public immediately, available to anyone with a computer anywhere in the world. No one would own the data. No one could submit patent applications, though private companies would ultimately profit from any drugs or imaging tests developed as a result of the effort.”

“ ‘It was unbelievable,’ said Dr. John Q. Trojanowski, an Alzheimer’s researcher at the University of Pennsylvania. ‘It’s not science the way most of us have practiced it. But we all realized that we would never get biomarkers unless all of us parked our egos and intellectual-property noses outside the door and agreed that all of our data would be public immediately.’ ”

Rural Hospitals Show Their Excellence

Four of the nine Wisconsin Forward Awards in 2010 went to rural hospitals: Black River Memorial Hospital, Grant Regional Health Center (Lancaster), Sauk Prairie Memorial Hospital and Stoughton Hospital. (All are RWHC Members!) The Wisconsin Forward Award program was created in to promote significant achievements in continuous improvement and performance excellence—business practices that ensure the economic vitality of Wisconsin organizations and the communities they serve.”

“Organizations participating in the WFA program are committed to the achievement of high standards of excellence. Whether they are just beginning their journey by using one of WFA’s self-assessment tools, or exemplify mature, productive quality management systems as outlined by the WFA Criteria, these organizations are distinguishing themselves as leaders in their field, enabling themselves to be as successful and innovative as possible—and keeping Wisconsin in a State of Excellence.”

“Stoughton Hospital was among three organizations recognized at the Mastery level, demonstrating significant maturity in developing and refining processes that are tied to good results in such areas as

building a high-skilled workforce, financial and organizational performance, and exceptional customer satisfaction and retention.”

“Regardless of the performance measure and size of organization, the research is clear—the long-term impact of effective performance management continuous learning programs can be linked with positive financial performance, customer satisfaction and improved employee involvement. The mission of Wisconsin Forward Award, Inc. is to promote and recognize the adoption of performance excellence principles and practices by Wisconsin organizations through enhanced continuous learning and quality improvement. The primary program focus is:

- Advance the competitive advantage of Wisconsin businesses and organizations
- Provide a method for self-assessment for Wisconsin organizations to achieve continuous learning and world-class performance improvement
- Promote recognition as a means of promoting the sharing of best practices in high-achieving Wisconsin organizations.”

For information on The Wisconsin Forward Award process go to: <http://www.forwardaward.org/>

Learning Heart Health the Hard Way

“Eye On Health” regularly showcases a RWHC member story from the Wisconsin Hospital Associations’ annual Community Benefits Report. Wisconsin hospitals provide over \$1.6 billion in community benefits; twice that if you include Medicare shortfalls and bad debt. This month is from the Shawano Medical Center:

“Imagine how it feels: You feel awful, you have chest pains, your heart is racing, and there is heart disease in your family. You’re only 40 years old and you’re afraid of having a heart attack. You need a stress test, x-rays—all the tests that can tell you whether or not you are at risk. Now imagine that you

husband has been laid off. You have no insurance, no income, no money. That's how Shawano area resident Marie Rouse felt when she first came to Shawano Medical Center (SMC). She was referred here by her family doctor. She knew she needed tests and knew she couldn't pay for them."



"They told me, 'Go ask Amy.' Amy Reiter is the financial counselor at SMC. She helps patients pay for services or directs them to programs like SMC's Community Care program, which reduces patients' hospital bills on an income-based scale."

" 'I expected to get a hard time. Usually that's what you get. But Amy was a very nice person. She helped me fill out the papers, the parts I didn't understand. And I qualified. It paid for everything except reading the x-ray,' Marie said. Fortunately, the test showed that her heart didn't require surgery. But her family doctor laid down the law. 'Eat right. Avoid stress. Plenty of exercise—moderate-pace walking. Lots of water. And no more yelling—even at the dogs!' "

"And Marie listened. She has lost over 20 pounds already, drinks lots of water, and eats fruits and vegetables. She can't say she's stress-free, but she does appreciate the support she gets from her family. They look out for her, Marie said. And a recent test showed that her work is paying off. Her latest test showed a heart that looked 'pretty good...normal.' "

"Without tests through Community Care, Marie said, 'I don't know what I would have done. I would have had to let it go—have a heart attack. If it wasn't for them we would have filed for bankruptcy. It's scary.' "

"Rural Health Access & Workforce"

This PPT was presented to the Wisconsin Legislative Council Special Committee on Health Care Access by Tim Size, RWHC Executive Director. Also presented for this session was an overview of "Quality of Care in Rural America." Both are available online at:

<http://www.rwhc.com/News/WhatsNew.aspx>

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