

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

Medical Schools Need Rural Input

From “An Open Letter Regarding a Rural Perspective on the University of Wisconsin's Medical School Dean Search, Screen and Selection Process” by the Rural Wisconsin Health Cooperative, sent to the University of Wisconsin-Madison Chancellor and Medical School Dean Search Committee; the letter's complete text is at <http://www.rwhc.com>:

I am writing this open letter at the request of the 29 community hospitals that own and operate the Rural Wisconsin Health Cooperative (RWHC) to suggest issues to be considered as applicants are reviewed for the position of Dean of the Medical School. We all need the Medical School to serve the state, but equally so, the Medical School best serves itself when it makes collaboration a core institutional competency. Secondly, we wish to formally state our objection to the lack of rural community and limited external representation on the Committee.

I appreciate having had the opportunity to meet with Professor Leavitt as well as several other members of the Committee in order to discuss our concerns. This letter is the result of the resulting suggestion that we submit examples of questions that we feel should be asked to the candidates. While “presence by proxy” is

a poor substitute for face to face participation, we are complying with this request.

It is our hope that the Committee members consider these comments and questions in recognition that “outside” rural voices are absent from the process in a way similar to the more frequently discussed underrepresentation of women and people of color “within” University leadership. It is not our intent to criticize

the individual members selected to serve on the Committee; we know that they have agreed to an extraordinarily time consuming and challenging job.

RWHC continues to believe that the University of Wisconsin, as one of the great land-grant universities, must excel in its ability to partner with the whole state, not just itself. We hope that the candidate selected by this process will understand that the Medical School's long-term success requires multiple external

collaborations. There is some reason to believe this is possible as there is a substantial body of peer reviewed literature that speaks to the self-interest of academic medical centers being well served through community collaboration.

The state's rural residents depend on the teaching and research mission of the Medical School to be both successful and relevant to them, which in turn requires the School to maintain a statewide clinical base. A critical part of this vision is the much publi-

RWHC Eye On Health



"I keep telling you; our job is to be academic and their job is to stay out of our business."

cized Transformation of the Medical School into a School of Medicine and Public Health; a vision that also includes the rural context. For the University to move forward, it absolutely cannot afford to retreat from the historic view that the boundaries of the University of Wisconsin are the boundaries of the state. Anything less is simply not comprehensive enough to be the basis, in terms of either political support or market share, for a viable medical school.

As a means of organizing specific comments and questions which we hope will be considered by the Committee and the Chancellor, much of the rest of this letter borrows liberally from the structure of “Managing Partnerships” a paper written by senior RWHC staff which details our experience re collaboration and was subsequently published in *Health Care Management Review*, Winter of 1993.

Collaborative Leadership Isn’t Always Traditional

If the University is serious about maintaining and developing external relationships, the following concepts must be kept in mind as this process proceeds:

- Significant management practices necessary for successful collaboration such as needed between the Medical School and “out-state” organizations are not commonly seen in traditional vertically organized institutions.
- Most administrators have had little experience and even less training regarding leadership within the context of collaborative models.

The **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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- The “natural” administrative response will frequently come out of traditions that may be inconsistent with the actions needed to support networking.
- The development of collaborative relationships can look deceptively easy but collaborative processes sometimes require more time up front than that needed in authoritarian models.
- Enlightened self-interest is necessary for organizations to work together.

Collaborative Leadership Skills and Experience

Below is a set of general questions we hope you ask each candidate. Validation of each finalist’s responses should also be sought by asking similar questions to leaders of the community organizations with whom the finalists have partnered:

1. Please talk to us about the role of “trust” in your prior work with external stakeholders. What examples can you offer of your ability developing trust in these “partnerships”? How did you do it? How was the relationship affected?
2. How would you structure and manage university-community collaborations to be a good return on the invested time and money of the faculty, the university and the community organizations? What is the value of such collaborations to the university? How do you ensure that the “tenure trap” not act as a counter incentive for faculty to be involved in service related initiatives? Relevant experience?
3. In your prior positions, how have you been able to make community partners feel useful, needed (beyond writing checks or lending support with State Government)?
4. Please give specific examples of how community partners and stakeholders have been invited into and participated in medical school or other university planning exercises. What did you see as the benefits and challenges in these instances. How would you do it differently today?
5. In what ways have you worked to promote collaborative solutions that have enhanced the self-

interest of both internal and external partners?
Please be specific.

Questions Specific to Rural Health in Wisconsin

Questions specific to the University of Wisconsin and the particular interest of rural communities in Wisconsin include:

1. Some have observed that, taken as a whole, the “culture” of the UW Medical School is unsupportive of rural health and primary care; if you found this to be the case, what would you do about it?
2. There is an initiative underway to create the Wisconsin Academy for Rural Medicine, a “school within a school” with a focus on improving the preparation of and distribution of graduates into Wisconsin’s rural communities. What is your experience in developing or helping to lead programs related to improving the distribution of physicians? What do you think are the most effective strategies?
3. Wisconsin has one remaining rural Family Practice Residency; what would you help to do to strengthen that site and potentially redevelop other sites?
4. The Wisconsin Partnership Fund For a Healthy Future (created by the Blue Cross/Blue Shield conversion) is a new resource for the state and for the Medical School. The purpose of the Fund is “to significantly advance public health through prevention of disease, injury and disability.” Many within and outside of the Medical School believe that, without strong leadership from the Dean, there is a substantial risk that this goal will be “transformed” to a more limited vision of primarily serving Madison campus interests. How will you exercise that leadership?
5. One goal of the Wisconsin Partnership Fund For a Healthy Future is to make Wisconsin the healthiest state; how can the Medical School best accomplish this goal in rural communities? What is the role of physicians in the future in rural Wisconsin and how can the Medical school best prepare them for that role?
6. The Wisconsin Partnership Fund For a Healthy Future is encouraging the University of Wisconsin

to partner with the Medical College of Wisconsin to develop a collaborative “Public Health” Leadership Institute with a mission “to develop transformational leaders who engage in innovative community health improvement activities and effectively protect and promote the health of the public.” Specifically, what do you hope this initiative will accomplish?

7. A key recommendation of the Institute of Medicine’s Report, *The Future of Rural Health Care. Quality through Collaboration* is that “Rural communities must reorient their quality improvement strategies from an exclusively patient- and provider-centric approach to one that also addresses the problems and needs of rural communities and populations.” What is the role of the Medical School with regards to this recommendation?
8. Most states have an Office of Rural Health, typically located either within state government or a university. What experience have you had with such offices and what would be your vision for the Wisconsin Office of Rural Health?

We hope the above observations and questions are helpful to the recruitment of a leader that will serve well both the Medical School and rural Wisconsin.

Oppose Medicare Rural Construction Ban

From “Oppose Medicare’s Proposed Construction Ban,” a policy brief by RWHC, 5/10/05; the complete text is at <<http://www.rwhc.com>>:

Rural community leaders across America Oppose Medicare’s Proposed Construction Ban. You, your colleagues, friends and neighbors need to:

1. **Ask your Congressional Representatives and Senators “to take all steps necessary to stop CMS from implementing any arbitrary deadline on Critical Access Hospital replacement or relocation.”**
2. **Write to the Centers for Medicare and Medicaid Services (CMS) to (a) explain why their**

Proposed Rule is bad for rural health in your community and (b) demand that they delete “the arbitrary deadline on Critical Access Hospital replacement or relocation in the Inpatient Prospective Payment System (IPPS) final rule.”

Background (National Rural Health Association):

“In its recently released Inpatient Prospective Payment System (IPPS) proposed rule the Centers for Medicare and Medicaid Services (CMS) only provides continued Critical Access Hospital (CAH) status for necessary providers that are building replacement facilities at another location and can demonstrate their construction plans began before December 8, 2003. This arbitrary date restriction is a broad overreach of CMS authority. It puts in jeopardy many relocation projects that were started in the year and a half since the passage of the MMA. It leaves no flexibility to relocate facilities in the future...”

Talking Points

Oppose the Medicare Construction Ban on Critical Access Hospitals because:

1. The Proposed Regulation transfers to the Centers for Medicare and Medicaid Services (CMS) control over the basic structure of local rural health care, a loss of local control never before seen, and if allowed to stand, a precedent that threatens all

hospitals and all communities.

2. It was clearly not the intent of Congress in the Medicare Modernization Act that a Critical Access Hospital (CAH) designated as a Necessary Provider be perpetually prohibited from replacing or relocating their facility, facilities that are often 40 to 50 years old.
3. 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.
4. Ironically, the CMS proposal to ban a local community’s ability to rebuild on an adjacent or nearby location will cost Medicare over time, more, not less—the higher labor costs of operating in a retrofitted building more than offset the slightly higher cost of rebuilding.
5. A ban on major construction projects developed after December 8, 2003 is an over reaction against a potential problem that can be appropriated managed by the portion of CMS’s proposed rule that would require assurance that, after the construction, “the CAH will be servicing the same community and will be operating essentially the same services with essentially the same staff.”
6. The CMS ban is based on the misguided belief, not tested in law and a break with CMS’s past policy, that the relocation of a CAH can be treated differently than for any other hospital. There is no basis in law that the relocation within a community of a CAH with Necessary Provider status constitutes a cessation of business and loss of its provider agreement and number.
7. A CAH’s Necessary Provider designation is associated with its current Medicare provider agreement which should remain intact unless the CAH fundamental changes its business (e.g., ceases its current operations) or is terminated by Medicare. It is a longstanding policy that the provider agreement describes the legal entity and services provided—not the physical structure or location.



Write to Congress

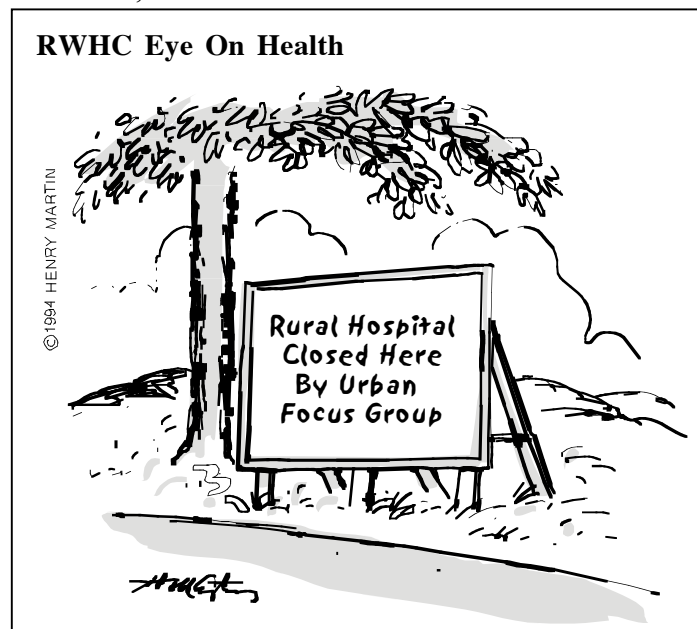
Ask your Representative/Senators “to take all steps necessary to stop CMS from implementing a deadline on Critical Access Hospital replacement or relocation.”

1. Call or write using Congressional office phone numbers and addresses available from:
<<http://mygov.governmentguide.com/>> or
2. Use the National Rural Health Association’s automated letter system at <<http://nrharural.org/>>; click on the “Advocacy/Regulatory” button and type in your zip code under “Write to Congress;” follow directions under Action Alert for “Critical Access Hospitals in Jeopardy.”

Comment on the Proposed Rule Before June 24th

Write to the Centers for Medicare and Medicaid Services (CMS) to (a) explain why their Proposed Rule is bad for rural health in your community and (b) demand that they delete “the arbitrary deadline on Critical Access Hospital replacement or relocation in the Inpatient Prospective Payment System final rule.”

Mail written comments (one original, two copies)
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1500-P, P.O. Box 8011,
Baltimore, MD 21244-1850.



Get the Bias Out of Public Reporting

From the policy brief, “Public Reporting of Hospital Quality in Rural Communities: an Initial Set of Key Issues” adopted by RWHC and proposed to the National Rural Health Association, 5/05; the complete text is at < <http://www.rwhc.com> >:

This policy brief intends to build on the National Rural Health Association’s existing Policy Brief *Quality of Rural Health Care* and in particular focus on issues related to the public reporting of hospital quality in rural communities. The development of this brief was triggered by the question, “How, from a rural perspective, can the Hospital Compare website (www.hospitalcompare.hhs.gov) be improved?” However, these recommendations are intended to be relevant to all hospital public reporting initiatives.

Given that public reporting of hospital quality is very much a “work in progress,” this policy brief does not pretend to address all issues or be the last word on the complex set of issues related to quality reporting and improvement. In particular it does not address the difficult question of how much should be invested in generating quality measures when medical records are still primarily paper and require manual abstracting. At a minimum, future NRHA policy briefs will be needed to address issues related to the public reporting of the quality of other providers and clinicians in rural communities.

However, given the significant resources already being invested in quality reporting and the potential impact on local rural communities and the hospitals upon which they depend, an initial set of public reporting principals or guidelines from a rural perspective is needed.

While relatively few people currently use information found on websites to make choices about where they seek health care, this is likely to change. Precedent is now being set. During this time of development we must ensure that the public reporting websites do not inadvertently carry forward biases against rural communities, providers and clinicians.

The NRHA has long advocated the need for rural providers to engage in the quality improvement and public reporting movement. **NRHA strongly believes in the proposition that rural communities deserve and demand the same high quality as other Americans.** At the same time NRHA emphasizes the unique context of rural healthcare and that models, policies and measures developed in an urban context may or may not work well in a rural context. As noted in “*Quality of Rural Health Care*,” rural America has unique factors that must be acknowledged and analyzed.

This work has been started, most notably by Ira Moscovice and colleagues at the University of Minnesota Rural Health Research Center. From the Center’s recent paper, *Measuring Rural Hospital Quality*: “While rural and urban hospitals share similar types of opportunities and challenges for organizing high quality of care, the relative importance of opportunities and challenges varies as a function of the hospital context. The work completed in this study identified the most relevant quality measures for rural hospitals with less than 50 beds from existing quality measurement systems. In the future, emphasis needs to be placed on developing relevant quality measures for core rural hospital functions (e.g. triage, stabilization and transfer; emergency care; integration of care with other local community providers) not considered in existing measurement sets.”

High quality hospitals are those hospitals that accomplish the Institute of Medicine’s six aims for health care and with their community, population health: safe, effective, patient-centered, timely, efficient and equitable. 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.

Policy Recommendations

1. Consumers should be able, at a minimum, to readily compare all hospitals in their “hospital referral region,” i.e. within the geographic service

area in which the preponderance of patients are treated and referred.

2. Hospital comparisons should be based on a core set of standard measures, even if lower volume hospitals must collect data for longer intervals to generate reliable results. Additional measures should be included to further describe the quality care in an array of more specific contexts, including but not limited to rural communities.
3. Hospitals in rural communities should fully engage in the quality improvement and public reporting movement, actively preparing for a future when public reporting is a higher priority among payers and consumers.
4. In all public reports, hospitals in rural communities should be presented in a manner that make it clear that they are “acute care hospitals,” defined by the Centers for Medicaid and Medicare Services on the Hospital Compare web site as “providing inpatient medical care and other related services for surgery, acute medical conditions or injuries.”
5. Information about how Medicare categorizes a hospital for payment purposes should be available to the public but should not be the primary basis for organizing a public report on hospital quality.
6. The appropriate comparisons are for the services rendered, not the size of institution. Hospitals in rural communities should only be labeled as “small,” “limited service” and “remote” when hospitals in urban communities are described as “huge,” “offering an excessive amount of services” and “built on top of each other” (i.e. neither description is a fair generalization).
7. All relevant stakeholders should be actively involved in the complete development process of public reporting websites targeted at rural communities, from measure selection to report presentation. All public reporting websites should be pre-tested with a representative sample of consumers and hospitals located from affected communities.
8. While all hospitals should have the opportunity to comment on the accuracy of the description of

their organization and services before a website goes public, the primary responsibility is with the web site owner to assure the accuracy of the information it offers. All sources of data and their known limitations must be cited. The site should have an on-line ability for site users to provide feedback.

9. While the National Quality Forum recommends NOT publishing performance rates when the denominator is smaller than 30 (other sources cite 25), there is significant disagreement about whether or not to publish the raw data in such instances; more research and debate is needed.
10. The visual presentation and graphics used on a website or in a report convey at least as much meaning as the text or data itself and must be as rigorously tested with the relevant audiences for unintended messages.
11. The visual presentation, graphics and text accompanying a hospital with small numbers should always put the onus on the website, not the hospital, for the statistical challenges related to interpreting small numbers (e.g. “we have not yet collected enough information to reliably predict future performance” rather than “be careful when drawing conclusions for these hospitals because of the small number of patients treated.”)
12. When there is a statistical challenge related to interpreting small numbers, symbols such as red flags or warning symbols should be avoided; “neutral” symbols should be selected so as to not suggest that there is a problem with the hospital.
13. Public reports need to be careful to not imply from partial inpatient data what services are available in other inpatient areas as well as the outpatient and emergency room departments (e.g. a hospital may provide care to a significant number of heart attack patients in its emergency room that are transferred rather than admitted.)
14. The national quality reporting movement must address the number of public reporting organizations and the continuing need for a common set of reporting formats and definitions.

The 2005 Nursing Excellence Award Winners

RWHC initiated the Nurse Excellence Awards to recognize high quality nursing practice provided by the hospitals serving rural communities. Nurses in community hospital settings must be well educated, well rounded at clinical practice, and have the ability to respond to a variety of age groups, diagnoses, and patient emergencies. Establishment of this award is public recognition that excellence in nursing practice is a valuable asset to rural communities and the state of Wisconsin. **The 2005 Nurse Excellence Awards are Suzi Okey of Prairie du Chien Memorial Hospital for Excellence as a Staff Nurse and Tracy Wurtzler of Stoughton Hospital for Excellence in Nursing Management.**

Tracy Wurtzler came to Stoughton Hospital as a nursing assistant 25 years ago and has been employed as a Registered Nurse there for 24 of those years. Tracy has served for the past six years as Manager of Surgical Services including the Operating Room, Post Anesthesia Recovery Room, Day Surgery Unit and Central Supply. Wurtzler was nominated by her peers and Nurse Executive Kristi Hund, who states “Tracy is respected as a leader for being a hard worker with enormous common sense combined with a fun nature that make it impossible for the department staff and physicians not to enjoy their job. She demonstrates that she has respect for employees and physicians and in return they respect her greatly.” Tracy is responsible for assuring state of the art nursing standards, is active on many diverse hospital committees and has multiple contributions to her credit.

Wurtzler is active in community events and activities that encourage individuals to enter the nursing profession. In the words of her peers, “Tracy likes to tease her co-managers that she isn’t up to the standards the rest of us are, but in fact it is really the other way around. We all wish for the kind of teamwork, support and results that Tracy gets. Tracy is perhaps the most outstanding example of natural leadership and Stoughton Hospital is tremendously fortunate to be the beneficiary of her talent, skills, and knowledge.” Wurtzler holds an Associate Degree from Madison Area Technical College in Madison, Wisconsin. She lives with her husband, Walter, and

their children, Stephanie, Erin, and Sheri in Stoughton, Wisconsin.

Suzi Okey, has spent most of her nine year nursing career at Prairie du Chien Memorial Hospital in Prairie du Chien, Wisconsin. Suzi works as a clinical staff nurse and is cross trained in obstetrics, medical/surgical, pediatrics, and long-term care. She has also oriented to both the emergency room and the intensive care unit. Suzi exemplifies rural nursing with her flexibility. She has attained ACLS certification, certification in caring for the oncology patient, fetal monitoring certification, trauma care certification, neonatal resuscitation and is a certified child birth instructor. She finished her BSN as a single parent while working full time last year.

Suzi's commitment to continuing education and development and patient care are amazing. Nurse Executive Ellen Zwirlein states "Suzi is truly an unsung hero. She is committed to providing the highest quality of care and is always willing to share, reaching out to comfort those in need, inspiring and instructing in both words and deeds and giving without seeking fame or glory." Suzi has worked with her hospital's

Fall Prevention Task Force and has worked on performance improvement activities in the OB department. A clear asset is her flexibility and her commitment to having expertise in all areas she works. The nomination states, "because of her passion to meet new nursing challenges, and her competency, compassion and flexibility, she sets the gold standard for her organization." Suzi lives with her daughter Dania in Cassville, Wisconsin.

Also nominated for the Nursing Management Award were Diane Bindl, Terri Langer, and Janet Volk all from Reedsburg Area Medical Center, and Carolyn Anderson from The Richland Hospital. Staff Nurse Award nominees include Kathy Benson from The Richland Hospital, Suzanne Eichorst from Divine Savior Healthcare, Charlene Galston and Marcia Hagen from Black River Memorial Hospital, Amy Henke from Memorial Health Center, Janet Kahler from Reedsburg Area Medical Center, Diane Schaaf from Upland Hills Health, Julie Stenbrotten from Stoughton Hospital, and Janice Wilson from St. Clare Hospital and Health Services.

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