Rural Wisconsin
Health Cooperative

Eye On Health

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

Fed Building Ban Hamstrings Rural Hospitals

Disbelief has been rapidly erupting into anger as the rural health community learns about a new Centers for Medicare & Medicaid Services (CMS) policy. CMS issued an inter-governmental "guidance" to State Survey Agency Directors on September 7th entitled, "Critical Access Hospitals (CAHs): Distance from Other Providers and Relocation of CAHs with a Necessary Provider Designation." (a.k.a. "Ref: S&C-07-35").

The following from John Eich, Director of the Wisconsin Office of Rural Health, describes the problem:

"In Wisconsin, we're seriously concerned about the latest Centers for Medicare & Medicaid Services (CMS) 'guidance.' It takes an unprecedented and particularly aggressive approach towards defining what is a Critical Access Hospital (CAH) relocation. Any move of beds, whether it be across town, on the existing campus, or even (as stated by a CMS representation at a recent National Rural Health Association conference in San Antonio) moving the beds into a newly constructed wing, is considered a 'relocation.' Despite current law and regulation, which state that once designated, 'Necessary Provider' CAHs will be grandfathered as a CAH, CMS now declares that any such relocating hospital must prove their case all over again if they wish to continue to be designated as a CAH and receive cost based reimbursement.

"Furthermore, the case the hospital will be required to prove is a more difficult interpretation of the criteria than originally administered. When CMS was asked to define what they meant by 'meeting the same criteria' as when they were originally designated, CMS replied that the exact same conditions on the designation form must be proven."

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"No need to rebuild old rural hospitals when we have perfectly good Army surplus MASH tents."

"To give an example, to achieve CAH status in Wisconsin a hospital must have shown that they met any 5 of 10 conditions. Today, in relocation, instead of applying that same 50% rule, CMS is demanding that our hospitals show they meet the exact same conditions on that list; any five are not good enough, they must meet the exact same five."

"So if the community's unemployment rate has improved, or percent elderly population has changed to be under the original threshold, the hospital loses their CAH status, even if they meet other conditions to make 50%. If the hospital originally met 8 of the 10, and put them down for good measure, they're held to those same 8 – so they're actually held to a different criterion – 80% versus 50% of the conditions."

"This literally different criterion effectively limits CAHs from upgrading their facilities by building on the edge of town, frequently the more cost effective and less disruptive approach. Indeed, with a new wing being considered 'relocation,' it may even limit them from upgrading by renovation. This is a backdoor sunset on the program, as rural hospitals can only run so long without system upgrades."

"When I was a kid my parents moved a lot, but I always found them." Rodney Dangerfield

"While all of us are interested in closing loopholes that permit a CAH to relocate to an area that is not in the spirit of their original application to become a 'Necessary Provider,' this approach goes way too far. Continuation of the '75% rule' (requiring that after a move the hospital has 75% of the same services, staff, population), along with an automatic approval of any move 'within 5 miles' would prevent potential 'abuse' but still allow small rural hospitals to upgrade their facilities when needed without losing their funding status, and in many cases here in Wisconsin, their viability."

Health Workforce Planning Blindfolded

by Tim Size, RWHC Executive Director

This editorial does not intend to throw stones at any department, organization or sector. Its focus is on Wisconsin but Wisconsin is not unique. We all must be part of the solution.

It is important to note that the Department of Workforce Development has given needed visibility to the overall problem of workforce shortages; it has generated reports based on currently available data and helped identify and is promoting needed best practices such as the voluntary "no-lifting" program. I would also like to acknowledge examples of important work such as the Wisconsin Hospital Association's "Who Will Care For Our Patients" (on the growing shortage and mal-distribution of physicians) or regional efforts such as the Fox Valley's excellent "Healthcare Workforce Retirement & Departure Survey."

How We Are Failing—Even with such efforts, Wisconsin's very own "inconvenient truth" is that we do not have a system to produce ongoing, statewide information that would allow us to make knowledgable projections about health care workforce shortages.

Due to limited resources and instances where collaboration needs to be substantially enhanced, our current approach to healthcare workforce planning falls far short because as regards to job vacancies, we don't know where we are or where we are going.

As regards to the strategic investments and changes that need to be made in and by Wisconsin's universities, colleges and schools we are playing a high stakes game of "blind man's bluff." Do we have the right number of nursing schools? Are we producing the right number of ADN and BSN graduates? Are we graduating enough physicians in the needed disciplines who are prepared to work in all of Wisconsin, not just selected communities? Isn't a second school of dentistry long over due, explicitly designed to address our states chronic shortage of dentists accessible to the uninsured? Can we change the share of our pharmacy graduates going into rural practice from 6% to something closer to a replacement rate of 30%?

The problem is that we have lots of data and not much information upon which to make knowledgeable workforce development decisions in or for either public or private sectors. We tend to know how many people are employed in various occupations but not whether they work full time or part-time or for multiple employers nor how many vacancies currently exist or are projected to exist.

What We Can Do—The Federal Health Resources and Services Administration has a Workforce Shortage Forecasting tool but its estimates for future shortages in Wisconsin are based on relatively small sample sizes and to date have been mostly limited to Nursing. We need to better understand the HRSA model, the "simplifying" assumptions it makes and the data inputs it needs to produce usable outputs.

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

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Regardless of what predictive model we end up using, its outputs will only be as good as the inputs; and good inputs require more collaboration than we have yet seen. Critically important data we need but currently do not have access to includes, but is not limited to (a) number of first time licenses by year, (b) number of license renewals (c) age of each license holder, and (d) for new licenses: the degree granting school and year the degree was awarded. We need to either mandate survey participation as part of the health professions licensure process or make it hard to avoid.

The professional licensing process in North Carolina and Minnesota is an integral part of the state's workforce planning process; we can and must do as well in Wisconsin.

We must also find a way for employers and academic institutions to join government in this work. Various claims of "it's not my responsibility" or we have a "proprietary interest in 'our' data" is crippling our ability to appropriately plan for our collective future workforce needs. We must develop mechanisms that aggregate survey data from regional and other efforts.

Once we have the data to mathematically project estimates of shortages and perhaps in some instances, surpluses, we need to have an organized infrastructure to turn the data into information and knowledgeable estimates that can inform our investments in education, training and other interventions. While we need to start with mathematical projections, by themselves they are not useful. We need to add what we know may or could be happening in too impact relevant policy that wasn't otherwise incorporated into the model's assumptions. We must look beyond statewide numbers to regional data analysis so we can understand and address how shortages vary around the state, with a particular focus on traditionally underserved communities, rural and central city.

We need to get real about resources. It would be helpful to know what the best practices are in other states regarding projecting specific healthcare workforce shortages; and what resources they allocate for the process. We are already behind in addressing in preparing for the future as Wisconsin (a) is a "graying state," with a larger proportion of its residents in or close to an age that typically brings a much higher need for medical care, (b) we already are facing significant shortage and maldistributions and (c) the lead time to make strategic changes in our healthcare education and training infrastructure is limited.

Wisconsin needs more caregivers at the same time workforce participation is declining. It was fun to play blind man's bluff as a kid but not now, given the high stakes of baby boomers retiring out of providing care and entering a stage of life where they will increasingly need it.

Due to limited resources and instances where collaboration needs to be substantially improved, our current approach to healthcare workforce planning falls far short because as regards to job vacancies, we don't know where we are or where we are going. This leaves us with an approach not too different than the phenomena in Congress where research dollars seem to flow mostly due to whose friends and family had what medical misfortune; infrastructure allocation by anecdote. Our future patients requires us to do better.

High US Chronic Disease Rates Cost Driver

From a press release, "American Adults More Likely Than Europeans To Be Diagnosed With, Treated For Chronic Diseases, Higher U.S. Disease Rates Contribute Up To $150 Billion In Annual Health Care Spending" by *Health Affairs*, 10/2/07:

"Older adults who live in the United States are significantly more likely than their European peers to be diagnosed with costly chronic diseases, such as cancer, diabetes, and heart disease, and to be treated for those diseases, adding approximately $100-$150 billion per year in U.S. health care spending, according to new research reported in a recent *Health Affairs* Web Exclusive. Americans are also nearly twice as likely as those who live in Europe to be obese, say Emory University Rollins School of Public Health researchers in the first study of its kind." The complete article is at: **http://www.healthaffairs.org/**

"Department of Health Policy and Management chair Kenneth Thorpe and team compared 2004 data on the prevalence and treatment of diseases among adults age 50 and older in the U.S. and 10 European coun-

tries (Austria, Denmark, France, Germany, Greece, Italy, Netherlands, Spain, Sweden, and Switzerland). They found that while 17.1 percent of European adults are obese, the rate is nearly double for American adults—33.1 percent. More than half (53 percent) of adult Americans are former or current smokers. In Europe, the rate is 43 percent. American adults were also more likely than Europeans to have chronic diseases, such as heart disease, cancer, diabetes, and chronic lung disease, that are correlated with obesity and smoking."

" 'We expected to see differences between disease prevalence in the United States and Europe, but the extent of the differences is surprising,' Thorpe said. 'It is possible that we spend more on health care because we are, indeed, less healthy. If the U.S. could bring its obesity rates more in line with Europe's, it could save $100 billion a year or more in health care costs.' "

"More specifically, the researchers estimated that per capita U.S. spending could be reduced by $1,195 to $1,750 per year if Americans age 50 and older were diagnosed and treated at the lower European rates for 10 common chronic conditions: heart disease; high blood pressure; high cholesterol; stroke / cerebrovascular disease; diabetes; chronic lung diseases; asthma; arthritis; osteoporosis; and cancer. Thorpe and colleagues estimate that this would reduce health spending by $100-$150 billion per year or would trim 12.7-18.7 percent off the total budget for personal health care spending among those age 50 and older."

"Explanations for the differences in disease prevalence remain varied. While it is possible that Americans are actually sicker than Europeans, it is also possible that more aggressive diagnosis and pretreatment of chronic diseases in this country raises disease prevalence rates, the researchers say."

"For example, Americans have higher levels of obesity-related disease markers, such as high blood pressure, so they appear to be actually sicker than Europeans. On the other hand, the higher rate of diagnosed cancer in the United States—more than double that of Europe—appears to be due to more intensive screening here."

"Researchers also found that the differences in the prevalence of chronic diseases affected the amount of medications used and treatments for those diseases. Despite the lack of universal health coverage in the United States, Americans age 50 and older were more likely than European adults to receive medications for six of nine conditions, including heart disease, diabetes, and asthma. This increased treatment for chronic disease and medication is helping drive higher health care spending in the U.S., the researchers conclude."

In (Partial) Praise of Silos

The following commentary was written for "Eye on Health" by Thomas E. Hoyer, Jr., Federal Center for Medicare and Medicaid Services, retired.

This essay does not intend to argue against effective coordination among Federal programs ("silos"). Specific advocacy in that direction, identification of specific barriers in and inconsistencies among programs could well lead to improvements. But be careful what you wish for. In a world of greater flexibility, it is much more likely that you would end up losing resources to other needs than that some utopian leader would make everything come out exactly right.

I've been working with rural issues for the Federal Government for almost a decade now and one of the most frequent images I encounter in presentations I see is the silo. I hear of many different ones, so it seems they must be useful for something; however, wherever the term silo is used, it is used to illustrate a problem in the administration of a rural health or human services program. Usually there is a suggestion that the customers would be better served if there were fewer strings attached to the assistance or if it were provided as a "block grant" so that State and local governments could use local wisdom to spend it in the right places—just one big silo with a big door at the bottom to make access easy.

It's easy enough to accept the notion that silos are a problem; that the health and human services programs available for rural areas are all sealed hermetically in separate silos, to the detriment of the intended populations. Certainly it is true that it is difficult to coordinate access to a variety of programs when each one is discrete, with discrete rules for get-

ting the help. If you get your advice from Harry Truman's fabled one-handed economist (no "on the other hand"), that's all you'll hear. There is another side to the discussion, though, and I'd like to present it here.

Write for the 16th Annual Monato Essay Prize

A $1,000 Prize for the Best Rural Health Paper by a University of Wisconsin student is given annually by RWHC's Hermes Monato, Jr. Memorial Fund. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at

http://www.rwhc.com/Awards/MonatoPrize.aspx

You use a silo to store something valuable and you also use it to dispense that commodity as you need it. It really needs to be able to fill at least two basic functions. One of them is to maintain the conditions under which the commodity can be properly fermented (e.g., damp and anaerobic). The other is to be equipped to dispense the commodity as it is needed. Beyond that, a third function is to separate your stuff from the stuff that belongs to other people. These are all useful functions.

If you're reading this newsletter, you're well aware of the competition for government dollars. They're needed for roads, education, urban development and any number of other things. Federal, State, and local governments collect dollars in the form of taxes and then they redistribute the money to the places where they believe it should go. The people who make those decisions are elected officials who are answerable to voters. These sentences may seem too obvious even to have bothered writing, but they hold the crux of the matter. What government does is to collect money and then to redistribute it, in terms of services or subsidies. There are always more interests appealing for help than there is money available to provide help.

The late Senator Proxmire's "Golden Fleece" awards were used to identify government spending decisions that seem on their face to be bad ones. For example, one award was to the Economic Development Administration of the Commerce Department for spending $20,000 in 1981 to construct an 800-foot limestone replica of the Great Wall of China in Bedford, Indiana. Another was to the Law Enforcement Assistance Administration for spending $2 million in 1978 on a prototype police patrol car that was never completed. The car was loaded with gadgets and building them would have cost $49,078 each (in 1978 dollars). I don't mean to defend such projects, but I'll bet that each of them was the unfortunate manifestation of a potentially useful idea.

Leaving bad decisions aside, let us think for the moment about good decisions. The recent tragic bridge collapse in Minneapolis led to a spate of articles reporting on the extent to which the nation's bridges currently need maintenance. An article in the *Christian Science Monitor* reported that the Congress had devoted $283 billion to "infrastructure improvements" but quoted other authorities as saying that $360 billion would be necessary. When the Congress looks around for sources of money to appropriate for such things, assuming it doesn't want to raise taxes, it looks to take money from existing programs. The sources of funds could well include the health and human services programs that make up "discretionary" spending.

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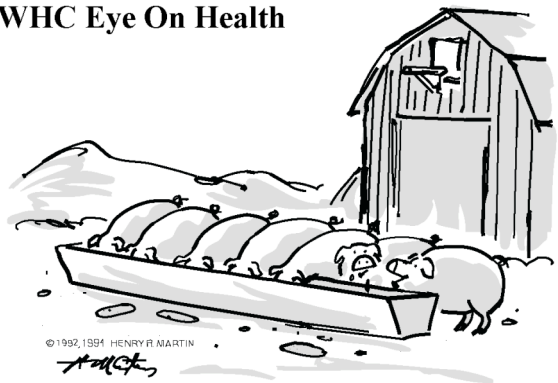

"I appreciate a full trough as much as the next pig but I keep wondering what's in it for the farmer."

When you think about all the individuals and organizations and governments seeking funds, you have to think that keeping "your" money some place safe makes sense. It is something the government does for you when it deducts Social Security and Medicare contributions from your paycheck. It is something you do yourself when you set up an IRA or open a Christmas club account or sign up for savings bonds or even just sit down at the kitchen table and sort your pay into different envelopes for different expenses. You may already have chafed at the thought that your IRA has a penalty for early withdrawal, preventing you from spending it on a new car or a new washing machine. I grew up in a large family, though, and it is quite clear to me that if my father had been able to get his hands on the money he contributed to Social Security, he'd have used it to send his children to college or on something else more important to him back then than his old age.

portant to him back then than his old age. These examples are some of the "silos" that limit your flexibility in spending your own money.

The Breast Cancer Recovery Foundation

BCRF sponsors *Infinite Boundaries* wellness retreats for breast cancer survivors. They nurture, enhance and aid the emotional, spiritual and physical recovery for women diagnosed with breast cancer.

BCRF has launched a new website that they hope will allow enhanced communication between BCRF friends, retreatants and women thinking about attending a retreat.

http://www.bcrf.org/

One way to think about those evil silos is to think of them in the same way as mechanisms to accumulate resources and earmark them for a specific use. If you look closely at the history of individual health and human services programs, you usually find that they were established as a result of strong and continuous advocacy, and that they are maintained because their citizen advocates and the Congressional advocates on the committees responsible for the programs fight hard to make sure that they remain separate and that each year they receive the resources required to provide the benefits.

It may be true that the ideal Governor or County Executive could be given all the available money in a single, unrestricted pot and that he or she would dispense it in the best interests of the State and its counties. But even then, could you be sure that the health and human service interests of which we are speaking would always be funded? Might it not be necessary at some point to spend the money instead on a new bridge or on repaving a critical road or building a convention center to rescue the businesses in an important city or simply to close an unexpected budget shortfall if the State Constitution requires a balanced budget?

Many years ago, I was part of an effort by the Secretary of Health and Human Services to look at the full range of programs whose funds went to provide services for persons with mental retardation and developmental disabilities—each program in its own legislative and administrative silo—with the view towards pooling the existing resources under a single, well thought out, well planned program that would assure the best use of the funds. The working group was a large one and it included parents of children with mental retardation and developmental disabilities and other advocacy groups. Everybody agreed that the existing configuration of programs was not particularly efficient. There was no shortage of suggestions for combining funds from one program into another. At the end of the day, though, there was a complete refusal to consider eliminating existing programs and combining the funds in a new program. The reason? The parents knew how much they depended upon the Medicaid benefit for Intermediate Care Facilities for Persons with Mental Retardation and Related Conditions (ICF/MR). They knew Medicaid was among the safest of programs. They were unwilling to risk the possibility that a new program with broad flexibility might be susceptible to reductions in funding that could harm their children. In the end, we concluded that there was really no constituency for change. People remembered how difficult it had been to get the programs passed and to get the silos built and filled up every year. There was no interest in the risk of starting over.

So it would appear that those hated silos might serve a useful purpose after all. They contain and protect the resources earmarked for the programs they represent. They lay down a marker each year on behalf of the programs, making it easier for the programs to win new appropriations. The procedures and rules for getting the services are more effective at keeping out people who are ineligible than people who need them. Those silos are the equivalent of an IRA or a Christmas Club account or a battered brown kraft paper envelope with the rent money in it.

Rural Hospitals & Their Larger Community

Each Month, "Eye On Health" will showcase a RWHC Hospital story from the Wisconsin Hospital Associations' annual Community Benefits Report. Wisconsin hospitals provide $1.6 billion in community benefit; twice that if you include Medicare shortfalls and bad debt. This month's feature is from Neillsville, Wisconsin,"Memorial Medical Center Educates Community on Dangers of Methamphetamine" by the Memorial Medical Center in Neillsville:

"The United Nations has called methamphetamine 'the most abused hard drug on earth.' It is one of the

most significant health threats to men, women, young and old, rural and urban areas, and the rich and poor alike. In one of Memorial Medical Center's most aggressive outreach programs, thousands of Wisconsin residents have now seen and heard the truth about the drug its own users call 'the devil.' "

" 'We didn't wait until our emergency department was saturated with meth users. Treating this epidemic on a patient-by-patient basis wouldn't work. We had to think bigger and act faster to reach people on a community-by-community basis. Our solution was to partner with the Clark County Sheriff's Department,' explained Karen King, registered nurse and ER/OR supervisor at the Memorial Medical Center in Neillsville."

"In December 2005, Memorial began collaborating with the Sheriff's Department and all Clark County municipal police departments to create a very real, eye opening program. Presentations were offered to the public free of charge. King and Sheriff's deputies were as open as possible about the current drug activity levels, locations of methamphetamine dump sites, and number of seized labs. To date, over 75 presentations have been made in five counties, reaching over 6,000 people via service organizations, medical facilities, law enforcement meetings, fire departments, schools, businesses, a regional Meth Summit, the Wisconsin Hospital Association's West Central Hospital Council, and the Wisconsin State Police Association drug training."

"On a local scale, our efforts contributed to healthier communities. In 2005 and early 2006, methamphetamine usage was on a steady increase in Clark County. By June of 2006, the Sheriff's Department reported a leveling of methamphetamine activity, and soon thereafter, a continual drop. Clark County has now achieved a 90% decrease in overall meth-related activities. In addition, both Memorial and the Sheriff's Department receive calls from both adults and students requesting information or providing tips to possible crime sites. At least one area school district plans to incorporate methamphetamine education into their permanent curriculum with hopefully more to come."

"Whenever possible, King still interviews meth users and dealers while they are in Sheriff's custody. According to King, their stories are basically always the same. 'Meth is the devil. I had no idea that using it one time would ruin my life. Stay away from it.' With their stories in mind, Memorial Medical Center continues educating people on the dangers of using meth, the signs of production, and the resources available for help."

Living With "Those People"

by Linda McFarlin, Health Officer for Adams County in Wisconsin and a member of the Wisconsin's Rural Health Development Council.

Residing in a rural community affords me an everyday experience in interacting with a kaleidoscope of people. Socio-economic distinctions are blurred by the small proximity in which each member of a small rural community lives, works, and engages in recreation. Richness of experience in living among the less fortunate in a rural community has enhanced my appreciation for "those people." "Those people" are made up of the economic disadvantaged, including a large number of elderly, young parents depending on public assistance, persons with mental health issues, and handicapped persons, perhaps living in a motel room with no kitchen facilities.

"Those people," as they are referred to, are a very important part of our community and provide me with experience I could not glean from my living among homogeneous populations such as in many urban and suburban neighborhoods. What I noticed most after having moved back to my childhood small community is that you cannot avoid exposure to "those people" because they may live next to you and/or they are in the grocery store, pharmacy, clinic, etc. with you. What a marvelous experience! Did you ever think of how they feel when I wait for them to walk past as I am backing out of my driveway? They stop for me before the driveway because that is their perceived pecking order in society. How about waiting, waiving them by, and seeing them smile because someone gave them the opportunity to go first? How easy it is in

suburbia to leave "those people" at the end of the work day and go home to a "safe" and prestigious environment. I even see these attitudes in my small community and worry about the lack of concern that some community members have for those less fortunate.

You see, I had the experience of situational poverty when growing up. My parents both died in their forties, and during the years prior to their death they were unable to work. I know what it feels like to be one of "those people." Yes, one of "those people" could be one of you people. Many Americans are only a few paychecks away from poverty and, even if you are now economically stable, how would you survive a long devastating disease? Have you considered which low income suburb you would live in; how you would pay your medical bills; how it would feel being in the "welfare" line?

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" 'Loving Thy Neighbor As Thyself' works best when you live in a gated community."

In your practice or business have you considered asking "those people" how they are doing, what worries they have, and if there is any food in the refrigerator? What about letting one of them cross the street in front of you or, better yet, helping one of them cross the street.

RWHC Passages

Rick Palagi, Sauk Prairie Memorial Hospital administrator, found the call of family and his beloved Montana too strong to resist. Rick was an active participant at RWHC from day one. His time with us was relatively short but his boundary pushing energy will be missed.

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