

Review & Commentary on Health Policy Issues for a Rural Perspective – November 1st, 2011

Cuts Impact Lifeblood of Rural Communities

by Stephen Brenton, Wisconsin Hospital Association,
and Tim Size, Rural Wisconsin Health Cooperative

We believe Wisconsin should be proud that its health care system provides high quality, cost-efficient care, and our rural hospitals are a key part of that equation.

In fact, 10 of Wisconsin's smallest hospitals, known as Critical Access Hospitals (CAHs), were recently ranked in the top 100 CAHs nationally. Yet right now there are proposals afoot in Congress that target these very hospitals, and by extension, the lifeblood of many rural Wisconsin communities. Both the Wisconsin Hospital Association and the Rural Wisconsin Health Cooperative are fighting these proposals on behalf of Wisconsin's hospitals and rural communities.

Almost 15 years ago Congress realized steps needed to be taken to keep the doors of many of rural hospitals open. They took action and created a new designation called the "critical access hospital." This new designation provided for an enhanced system of Medicare payments designed for rural hospitals and the local services they provide. As the name suggests, CAHs provide *critical access to care* in rural areas for rural populations. Wisconsin has 58 critical access hospitals.

With all eyes now focused on the federal deficit, these smaller hospitals, like their larger urban and suburban counterparts, have become a target for Medicare cuts by Congressional deficit negotiators. Whether the proposed cuts stem from eliminating the CAH designation altogether (which could lead to hospital closures), to changing program requirements or reducing payments, all will negatively impact vital economic engines in rural areas.

Rural hospitals are often one of, if not *the* largest local employers in many areas. Statewide, Wisconsin hospitals generate \$28 billion of economic activity and account for one of every nine jobs—jobs that provide family-supporting wages with ripple effects throughout communities.

We heard it put recently that "if you lose a hospital, you lose a town." We could not agree more and ask our Members of Congress to continue their strong support for Wisconsin's rural hospitals by standing with us against ill-advised deficit reduction proposals. Rural seniors and communities deserve top-notch care provided by health care providers

in their local communities. Cuts to rural hospitals do nothing to serve these desired goals.

Stephen Brenton serves as President of the Wisconsin Hospital Association, which represents 132 hospitals, including 58 Critical Access hospitals. Tim Size is Executive Director of the Rural Wisconsin Health Cooperative, which is owned and operated by 34 rural acute, general medical-surgical hospitals.



“We need more people in our district that can be fooled some of the time.”

This Isn't a Drill—Speak Up for Rural Hospitals

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative

This is not a monthly test of your outdoor warning siren. I have worked in rural health for over thirty years. We have never faced a situation as threatening as the federal cuts that may hit rural hospitals.

Senator Tom Coburn (an Oklahoma Republican) speaks for many when he said he understands the need to be careful when scaling back government spending. As he told Fox News, “to continue to waste \$350 billion a year in the federal government, that’s pure waste or fraud or duplication.”

Waste is often in the eye of the beholder. From my point of view, a strong rural health system is not “waste or fraud or duplication.” America’s rural hospitals are the foundation of health care being local, not just urban. America’s rural hospitals are often at the center of a rural community’s economy. Weakening or eliminating rural hospitals weakens or eliminates local access to health care and local jobs.

I am hopeful that Senator Coburn and other Members of Congress from both parties remain solidly behind rural hospitals. But it is clear that the debt crisis is fertile ground for the surfacing of longstanding anti-rural bias and or plain misunderstandings. In particular, rural hospitals seem to be in the crosshairs from a variety of directions.

After decades of trying unsuccessfully to impose an urban-based model of Medicare funding on rural hospitals, Congress created the Critical Access Hospital program to create a stable network of rural hospitals throughout rural America. That success is now threatened by a variety of proposals, ranging from eliminating some hospitals, across the board cuts or eliminating the entire program.

There is a risk of rural communities being divided from one another, seeing less threat in one proposal

versus another. I can only say that when your house is threatened by fire, it’s not the time for talking about which parts to protect and which to let go.

We know that most rural hospitals are financially just holding their heads above water. Under-payment by government programs has left them vulnerable. A sluggish economy and an increasingly competitive health care marketplace are taking their toll. Medicare and Medicaid are rural hospitals’ largest payers. Additional cuts are likely to tip many rural hospitals into the red and eventual closure.

No one knows what is going to happen in Washington over the next few months. As the Serenity prayer teaches us: we need to have the courage to act, the patience to endure and the wisdom to know the difference. I hope for most of you, you will find this a time to act.

Go to www.contactingthecongress.org where you can easily find the phone, email and fax information for your Senator and Representative. Let them know of your deep concern for the future of rural hospitals and that you are asking them to stand with you and fight to protect that future for rural America.

Insurance Exchanges Need to Work for Rural

The following is from RWHC comments to the Centers for Medicare and Medicaid Services (CMS) on the proposed rule for establishing Affordable Insurance Exchanges (Exchanges) and determination of qualified health plans. The complete set of comments will be posted by October 30th at www.RWHC.com.

Consider Explicitly the Impact of Competitive Forces and Public Policy on Rural Communities and Rural Health Care Systems—“Rural places and their residents have unique circumstances that must be considered and addressed in the development of Exchanges. It is important to note that rural patients face the most daunting of health care challenges: they are

20th Annual \$2,500 Monato Essay

A \$2,500 Prize for the Best Rural Health Paper by a University of Wisconsin student. Write on a rural health topic for a regular class and submit by April 15th. Submission info available at www.RWHC.com

older, poorer and sicker. Rural America is less healthy due to too much smoking, drinking and eating, and too little exercise, education, jobs and income.”

“ ‘Because the structure of the health care system, the characteristics of the population, and other facts of rural life differ in significant ways from the urban experience, the market and policy effects of these forces in rural areas can be quite different from the effects in urban areas. The consequences of the failure of a provider, whether it be a health facility or a health professional’s practice, are potentially greater in rural areas. Because alternative sources of care in the community or within reasonable proximity are scarce, each provider likely plays a critical part in maintaining access to health care in the community.’ (Urban Institute: ‘Supporting the Rural Health Care Safety Net.’ 2000)”

Assure Network Adequacy and Accessibility—“Enforcement of community access standards for Exchanges is absolutely critical to prevent steerage of enrollees and inordinate leverage by health plans against

rural providers. To that end, it is important that all Exchanges meet strong access standards. As an example, the current Medicare Advantage program statutes and

regulations have required CMS to ensure that plan enrollees have reasonable local access to covered services.”

“Incorporation into the risk adjustment mechanism of a cost adjustment factor for providing care in rural localities will reduce the pressure on health plans to ‘red line’ rural enrollees—to not enroll them. Insurers who are committed to providing local access and who attract more rural enrollees are more likely to see their enrollees using rural providers who face higher stand-by costs and lower economies of scale. This risk is equivalent to other variables tradi-

tionally controlled for in a risk adjustment model; methodologies exist and can be adapted to specific state circumstances.”

Promote State Level Exchanges—“RWHC sees the Exchanges as a critical tool for expanding access to health insurance coverage, while fostering value-based competition among private plans to promote quality and efficiency. We were proud to support Wisconsin’s effort in applying and receiving funds through the Early Innovator grant to establish Exchanges. Exchanges are particularly important in rural communities as they are in general more dependent on the individual and small group markets. To the detriment of rural communities, many have seen these markets as being less functional than the market for larger employers.”

“We believe that it is critical for each state to establish an Exchange that is consistent with Federal requirements rather than using the national default exchange.”

“These entities provide a market-driven policy solution that will help expand access to insurance for all individuals. We realize that some have argued that national health plans are antagonistic to individual state Exchanges and much prefer to compete within the context of a single set of rules determined by the Federal gov-

RWHC Eye On Health



“To keep health insurance exchanges is just about ‘not throwing the baby out with the bath water.’ ”

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.

Tim Size, RWHC Executive Director & EOH Editor
880 Independence Lane, Sauk City, WI 53583

Website: www.RWHC.com  : [RWHC](https://twitter.com/RWHC)  : [RWHC](https://www.facebook.com/RWHC)
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ernment as default for those states who do not establish an Exchange by 2014.”

“However, we believe that there are many high-value in-state insurance products that have developed and that these products will better continue to flourish with state-based Exchanges. We believe the quality of products will increase more if Exchanges facilitate a consistent set of metrics that are the focus of any incentives by health plans within the Exchange.”

Assure Rural Relevant Risk Sharing—“RWHC understands and supports the value in the pooling of risk amongst insurers that occur amongst qualified plans for sales both inside and outside of the Exchange. By pooling risk across a larger portion of the population relative to the individual market, Exchanges will spread risk and create a much more stable market place. Exchanges can both reduce premium costs for residents and attract a greater volume of health plans to the market.”

“In the past, many health plans have competed on who was best at avoiding sick people. The elimination of medical underwriting is hugely important to this principle, but it could be lost if the individual mandate and accompanying tax credits is eliminated as a consequence to adverse action by the courts.”

Assure Reduced Administrative Costs—“Exchanges can also reduce the administrative burden and costs—for small business and for individuals—of shopping for and enrolling in health insurance. By centralizing the research and shopping portion of the process, Exchanges save individuals and companies time. Exchanges that deliver real-time premium rate quotes and have a single interface for enrolling in all available plans, reduce time and save money for buyers. Consumers have enjoyed similar systems for shopping online and can handle comparison shopping.”



Safer Ladder Use

- “Inspect ladders before use. Make sure that the rungs are intact and free of dirt and paint buildup that could interfere with footing.”
- “When extending or retracting an extension ladder, hold the pulley rope firmly; if the rope is released, the upper section could drop on your fingers, arms or feet.”
- “Follow the ‘four contact’ rule: When using an extension ladder, make sure that the tops of both rails make solid contact with walls, and that both legs make solid contact with the floor or ground.”
- “Never stand higher than the third-highest rung on a ladder. Make sure that the ladder reaches at least three feet higher than the highest level you need to stand.”
- “Place foam protectors or wads of cloth on the tops of extension ladders, to prevent them from sliding and to protect the walls.”
- “On a stepladder, make sure the spreader bar is fully extended and locked in place.”
- “With a straight or extension ladder, make sure that the base is one foot away from the wall for every three feet of height.”
- “Make sure your pockets are empty of knives, scissors or other pointed tools before climbing any ladder.”
- “When on the ladder, keep your hips between the rails for good balance.”
- “Do not push or pull too hard on a scraper or other tool while balanced on the ladder.”
- “Always wear rubber-soled or another type of non-slip shoe on a ladder.”

Source: Tyler Mt. Volunteer Fire Department
Cross Lanes, West Virginia

Ignoring Evidence & Economics at Our Peril

The following is from “Ignoring Evidence & Economics at Our Peril” a post by David Kindig, MD, PhD, at www.improvingpopulationhealth.org/blog/

“Two recent *New York Times* articles jumped off the page at me. The first, on the recommendation by the U.S. Preventive Services Task Force to forego routine screening for prostate cancer with the PSA test, received wide media coverage. The second, on an Institute of Medicine (IOM) panel recommendation that costs should explicitly be considered in deciding what benefits must be provided by insurance plans, received less attention. Both deserve attention from population health advocates and policy makers.”

“The reason for the PSA recommendation is that the best scientific evidence reviewed by the panel over several years shows that such routine screening does not save lives overall and ‘often leads to more tests and treatments that needlessly cause pain, impotence and incontinence in many.’ Health care groups and patient advocates were quick to criticize the panel’s findings, in a similar pushback to the recommendation two years ago against routine mammography for women in their 40s.”

“While most of the PSA test media coverage has focused on effective care, we should also consider the panel’s recommendation from a cost-containment imperative. The fact is, resources are becoming increasingly limited and both Republicans and Democrats agree that Medicare spending must be reduced to reduce debt—and, some argue, protect national security in the global economy. Some facts to consider:

- As much as 25% of all health care expenditures are considered ineffective;
- Miami spends twice as many Medicare dollars per person as Minneapolis but gets no better results;
- We spend much more than any other nation on health care, with worse results.”

“There are two ways to achieve

AgriTalk Interview re Potential of Rural Medicare Cuts

Mike Adams, the host of AgriTalk, interviews
Tim Size, RWHC Executive Director.

The podcast is from the 10 min mark to 24 minute mark at:

<http://www.agritalk.com/podcast.php>

cost savings: provide fewer services and/or charge lower prices for each service. Any mention of this triggers loaded words from ‘rationing’ to ‘government death panels.’ I believe that

while limiting services which have benefit is ethically and analytically challenging, eliminating those such as PSA screening with no benefit and even harm is not. But we must keep in mind that personal, professional, and political interests do not always align with the evidence: the *New York Times* article asserted that health reform legislation requires Medicare to pay for PSA screening regardless of the panel’s findings.”

“That the IOM committee should have to make a case for cost consideration in benefit design indicates how far from rationality we have strayed. I believe we can get back on track by agreeing that:

- Cost containment is a national security priority;
- We are wasting resources now;
- We should channel our resources toward cost-effective investments in prevention and the social determinants of health (the Obama administration is very short-sighted in proposing \$3.5 billion in cuts to the already modest Prevention and Public Health Fund);
- We have opportunities to shift resources from ineffective health care to population health through community benefit reform and innovations from the Centers for Medicare and Medicaid Services (CMS).”

“We can’t have it both ways. We can’t lower costs without considering them. If evidence is not used to guide policy choices, what is the alternative? Perhaps we do need ‘shock therapy’ to have evidence and economics drive our policy thinking. We can’t solve our health care and population health challenges without it.”

David A. Kindig, MD, PhD is Emeritus Professor of Popula-

RWHC Eye On Health



“I’ve the right to pay for a test with no benefit but not to ask others to do so.”

tion Health Sciences and Emeritus Vice-Chancellor for Health Sciences at the University of Wisconsin School of Medicine and Public Health.

Wipfli-RWHC Promote Cost Champions

Rural hospitals have always been expert at providing local care at as low a cost as possible—reflecting the conservative values of their communities.

The “Wipfli-RWHC Cost Champions Award” has been launched to ***“encourage and share implemented cost savings ideas suggested by a team or individual employed by a RWHC rural hospital.”***

This annual award will focus on those teams and individuals who know rural hospitals best and are working hard to eliminate unproductive costs. The awards come with the following generous support of Wipfli, LLP: First Place: \$1,500 and Honorable Mention (two): \$500 each.

All employees of RWHC hospitals are eligible except the hospital administrator and his or her executive team. The awards will be sent directly to the nominating hospital for distribution to the nominated employees as a cash award or in a manner consistent with hospital policy.

RWHC member CEOs will be invited each year to submit one nomination by January 31st of a hospital a team or individual’s cost savings idea implemented in the prior calendar year. An application for RWHC members is available at www.RWHC.com.

Wipfli and RWHC will publicize the winners’ names and positions along with a brief description of all ideas submitted in order to encourage the more rapid pick up of good ideas across all rural hospitals.

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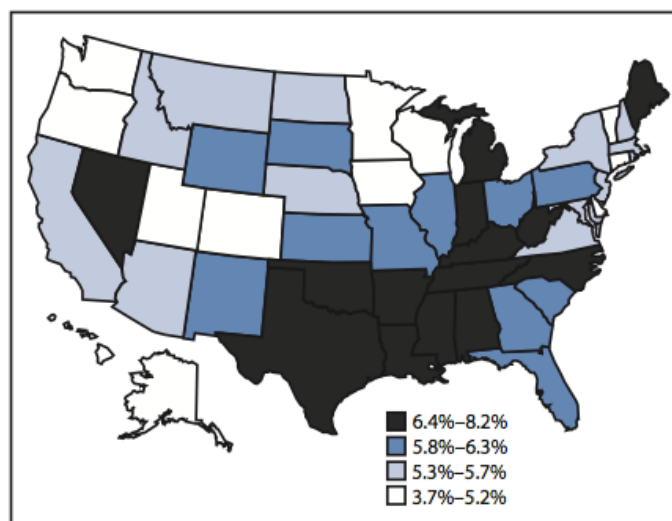
Cheeseheads Have Lowest Heart Disease in US

From “CDC: Coronary Heart Disease Declines in U.S.” from www.thestatecolumn.com, 10/14/11:

“According to the Centers for Disease Control and Prevention (CDC), the prevalence of coronary heart disease is declining in the U.S. Surveys from the Behavioral Risk Factor Surveillance System (BRFSS) found that between 2006 and 2010 there has been a significant decrease in overall coronary heart disease, from 6.7 percent down to 6 percent.”

“The authors report that the decline in coronary heart disease mortality over the past 50 years should result in an increase in the coronary heart disease prevalence. However, to explain their findings, they believe the observed decline in observation is due to a reduction in the population pool of individuals at risk.”

FIGURE. Age-adjusted prevalence of coronary heart disease among adults — Behavioral Risk Factor Surveillance System, United States, 2010



“Their reports included extensive data about the differences in coronary heart disease prevalence based on age, sex, race/ethnicity, education, and state of residence.”

“Coronary heart disease prevalence was generally highest in the south. In 2010, Hawaii and DC had the lowest prevalence, 3.7 percent and 3.8 percent respectively. West Virginia and Kentucky had the highest prevalence of coronary heart disease, 8 percent and 8.2 percent. **Most surprisingly, Wisconsin had the lowest rate of heart disease in the nation, a rate of 4.9 percent.**”

“Additionally, the risk of heart disease was influenced by age. The lowest rates of heart disease were among younger people, under the age of 65 years old. In 2010, nearly 20 percent of individuals 65 years old and older had heart disease, compared with about 7 percent of individuals who were between 45 to 64 years old, and about 1 percent of individuals between 18 to 44 years old.”

“Education appeared to influence heart disease prevalence. Heart disease was more prevalent among people without a high school diploma, 9.2 percent. People with some college education had a 6.2 percent prevalence rate, and those with more than an undergraduate degree enjoyed the lowest rate of 4.6 percent.”

“Women tended to have lower rates of heart disease than men, 4.6 percent and 7.8 percent, respectively.”

“Lastly, ethnicity appeared to play a role as well. The greatest declines in heart disease were among Caucasian people, from 6.4 percent in 2006 to 5.8 percent in 2010. Similarly, Hispanic Americans had a significant drop in heart disease, from 6.9 percent to 6.1 percent in 2010. On the other hand, the rate of heart disease increased among blacks, from 6.4 percent to 6.5 percent. American Indians/Alaska Natives had the highest prevalence of heart disease, at 11.6 percent, according to the CDC.”



Managers Use Email or Face-to-Face?

The following is from the October Issue of RWHC's Leadership Insights newsletter by Jo Anne Preston. Back issues are available at:

www.RWHC.com/News/RWHCLeadershipNewsletter.aspx

“As a manager, it can seem more *efficient* to text or email when you need to communicate with your employees, especially when you manage ‘virtually’ to multiple locations. You can’t always do things face-to-face, but how do you decide?”

Consider the following factors before hitting ‘send’...

Email usually works fine for:

- “Clarifying steps in a process or *decision you have already discussed* with the person
- Exchanging information that is *not emotional* to employees
- Reporting progress on something you or your employees have done before (it is *not new* or different)
- When there are *clear lines of responsibility* as to who does what
- Touching base on a relationship that already has a *sound basis of trust*
- Getting out the facts on *non-complex* issues
- To give employees a *heads up* about what you want to discuss in a meeting, especially if you set this up as a regular way of doing business (*i.e., ‘Every Monday, email me your agenda items for our coaching session and I will add mine and return to you by Tuesday so that we both know what we need to be prepared for.’*)
- Praise and *recognition* can work in email
- In *follow up to a face-to-face* discussion where decisions or agreements were made to document it (*i.e., ‘Here is my understanding of our agreement...’*)”

Better make it face-to-face when:

- “*Emotions* may be running high or have the potential to
- It is a coaching discussion about *any kind of underperformance*

- *Performance reviews* and *goal setting* sessions
- You *need their buy-in*
- You *need to establish a relationship of trust* because the person is new or there has been conflict
- There is the chance that the *employee doesn't understand their role* or boundaries
- *Collaboration* is important to getting the job done
- Announcing a *major change* in the department
- It becomes a *back and forth 'email discussion'*
- The work is *new territory*, not something that has been done before
- You want to recognize an employee that goes way above and *beyond the call of duty*
- It is *anything that is going to be hard to hear*, particularly if it has not already been talked about
- You are feeling *out of touch* with your employees
- You start hearing *concerns about employees* from others and you have not seen the behaviors"

You can strengthen your leadership with *intentional* communication practices:

1. "If you are emotional when you compose email, walk away from it before you hit send. You may regret it otherwise.

2. For that matter, if you are emotional before a face-to-face conference, address that before you start too.
3. Generally when in doubt about email or not, go face-to-face.
4. Consider how people would rate your 'presence' in the department. For some, it equates to accessibility to see you once in a while.
5. Some simple basics when you do use email matter more than you think and can help you engage people: do use a greeting and their name, thank them at the end, avoid using all caps, and include signatures with contact information."

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

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