

Review & Commentary on Health Policy Issues for a Rural Perspective – June 1<sup>st</sup>, 2008

## Rural Hospitals' Charitable Exemption

by Tim Size, RWHC Executive Director

America is a large and noisy place. We are a people with strong conflicting beliefs and self interests. I only have to go back to my mother's grandfather to be at our country's Civil War. Today, maybe the loudness of endlessly broadcast shouting commentators makes it hard for us to see what we hold in common.

People and countries around the world mostly organize themselves to provide services in three ways—through family and friends, through for-profit businesses or through government. In America, more than anywhere else, we have a robust fourth way we call non-profit charities—churches, hospitals, voluntary fire departments, to name a very few.

Non-profits are a key component in American health care and to rural health in particular. The backbones of rural health are what we call hospitals, developed by communities and religious orders to serve critical local health needs. Initially the focus was on caring for a patient in a bed. Now it also includes outpatient care and the health of the community. These hospitals' core purpose has always been to minimize the effects of disease and injury and to maximize health. Non-profit hospitals reinvest all of their "profit" in that purpose.

"When I was younger, I could remember anything, whether it had happened or not." Mark Twain  
RWHC Eye On Health

To do this well requires non-profit board leadership fully exercising their responsibilities on behalf of the wider community. At that same time, the board needs to allow their administrator to administrate. Keeping and respecting this balance is at the heart of every successful non-profit.

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Senator Chuck Grassley of Iowa, a long time champion of rural hospitals, is leading Congressional action to restore the distinction between "non-profit" and "for-profit." While for-profits focus on making money for their owners (such as my retirement fund), all non-profit gains must serve and be reinvested in the wider community.

We are in an unsettled period of redefining what is and is not appropriate non-profit behavior. The Internal Revenue

Service has greatly expanded what non-profits must report as community benefits. While there is growing agreement about what constitutes "community benefit," it is a work in progress. As all levels of government are increasingly desperate for tax revenue, you can expect non-profit tax-exemptions to come under even tighter scrutiny.

If you live in a community with multiple hospitals within a mile or two, the continuation of any one hospital is not in and of itself a community benefit. While most rural non-profit hospitals would meet any definition of community service, most definitions fail to acknowledge a non-profit rural hospital's central purpose. These hospitals were created and are main-

tained by their communities or sponsors to provide care locally—care that without these hospitals, would not be available locally.

Running a rural hospital has always been hard work given the uncertainty of patients' needs from one day to the next, the higher rural costs of doing business and the perpetual challenges of recruiting professional staff. While there are exceptions, rural hospitals have not generally been a magnet for for-profit enterprise.

We need to assure that the growing regulation of non-profits and their charitable exemption recognizes the community benefit most central from a rural perspective. Providing quality and reasonably priced care locally is a rural community benefit.

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## Rising Mortality Rates Affect All of Us

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From “The Reversal of Fortunes: Trends in County Mortality and Cross-County Mortality Disparities in the United States” by Ezzati, Friedman, Kulkarni & Murray in *PLoS Medicine* (*PLoS Medicine* provides an open-access venue for important, peer-reviewed advances in all disciplines.)

**Background**—“It has long been recognized that the number of years that distinct groups of people in the United States would be expected to live based on their current mortality patterns (‘life expectancy’) varies enormously. For example, white Americans tend to live longer than black Americans, the poor

**Rural Wisconsin Health Cooperative**, begun in 1979, 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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tend to have shorter life expectancies than the wealthy, and women tend to outlive men. Where one lives might also be a factor that determines his or her life expectancy, because of social conditions and health programs in different parts of the country.”

**Why Was the Study Done?**—“While life expectancies have generally been rising across the United States over time, there is little information, especially over the long term, on the differences in life expectancies across different counties.”

**What Did the Researchers Do and Find?**—“The researchers looked at differences in death rates between all counties in US states plus the District of Columbia over four decades, from 1961 to 1999. Over these four decades, the researchers found that the overall US life expectancy increased from 67 to 74 years of age for men and from 74 to 80 years for women. Between 1961 and 1983 the death rate fell in both men and women, largely due to reductions in deaths from cardiovascular disease (heart disease and stroke). During this same period, 1961–1983, the differences in death rates among/across different counties fell.”

“However, beginning in the early 1980s the differences in death rates among/across different counties began to *increase*. The worst-off counties no longer experienced a fall in death rates, and in a substantial number of counties, mortality actually increased, especially for women, a shift that the researchers call ‘the reversal of fortunes.’ This stagnation in the worst-off counties was primarily caused by a slow-down or halt in the reduction of deaths from cardiovascular disease coupled with a moderate rise in a number of other diseases, such as lung cancer, chronic lung disease, and diabetes, in both men and women, and a rise in HIV/AIDS and homicide in men. The researchers’ key finding, therefore, was that the differences in life expectancy across different counties initially narrowed and then widened.”

**What Do these Findings Mean?**—“The findings suggest that beginning in the early 1980s and continuing through 1999 those who were already disadvantaged did not benefit from the gains in life expectancy experienced by the advantaged, and some became even worse off. The study emphasizes how important it is to monitor health inequalities between different groups, in order to ensure that everyone—and not just the well-

off—can experience gains in life expectancy. Although the “reversal of fortune” that the researchers found applied to only a minority of the population, the authors argue that their study results are troubling because an oft-stated aim of the US health system is the improvement of the health of ‘all people, and especially those at greater risk of health disparities’ ”

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## Employer-Based Health Reformed Away?

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From “Employment-Based Health Benefits Under Universal Coverage” by Paul B. Ginsburg in a *Health Affairs* issue focusing on “Health Reform Revisited,” May/June, 2008:

“With employer-based coverage eroding and single-payer approaches limited to expansions of Medicaid and SCHIP for low-income people, what should the role be for individual insurance as part of a universal coverage program for the United States?”

**Insurance exchanges for those without access to employer coverage?** “The first would create insurance exchanges to serve those without access to employer-based coverage, so that the individual insurance market serves them more effectively than what is out there today can do. Presumably, all receiving subsidies (including tax credits or deductions) to purchase private coverage would be directed to obtain their coverage through the exchange. This is the model that Massachusetts has pioneered in its reform.”

“Under this first option, care should be taken to limit the degree to which the individual market (outside of insurance exchanges) attracts healthy people away from their employer coverage. As long as those receiving tax benefits or subsidies are required to use the exchange, then plans could be directed to vary premiums on the basis of age and medical history by only limited amounts. So a person who is contemplating leaving an employment-based plan would not have an option of being rated on the basis of individual characteristics. In a sense, such a person would go from one pool with a mix of enrollee characteristics to another. Efforts to limit attrition of healthy people from employer plans could be seen as paralleling the efforts that the federal and state governments have

made to limit the extent to which expansions of Medicaid and SCHIP crowd out private (mostly employer-based) coverage.”

**Replace employer insurance with individual insurance?** “The second option would go much farther by also replacing employer-based coverage with individual insurance obtained through insurance exchanges—along the lines of the Wyden-Bennett or CED approaches. Although this approach has some attractive features, I believe that it is premature to abandon employer-based coverage with a strategy that is so untested in the real world. At this point, insurance exchanges are, for the most part, an attractive concept developed by thought leaders. Many design issues will have to be thrashed out in the policy process, and many operational problems are likely to be encountered and will need to be worked through. It would be better to do this learning with the tens of millions of people without access to employer-based coverage than with the entire privately insured population. This would both limit the numbers involved and engage only those with the most to gain from reforming individual insurance markets. It is not yet clear whether insurance exchanges can achieve the low distribution costs of employers or the value that a benefit manager brings to this complex marketplace. Framers of universal coverage proposals believe that they have learned from experience about the perils of threatening large numbers of people who are happy with their health insurance with major changes in how what is available and how they obtain it.”

**Summary**—“When one looks at the innovations in insurance coverage in recent years, most were initiated through large employers’ directing their carriers to develop and implement them. This includes wellness and health promotion initiatives, high-performance networks, pay-for-performance, tiered cost sharing for prescription drugs, centers of excellence, value-based benefit designs, and Health Savings Accounts (HSAs). Since the same carriers that administer insurance for large employers sell insurance to small employers, the most successful have also become available to the latter. Only HSAs developed more rapidly in the individual insurance market, and this is likely because such products are the only option for tax benefits for those obtaining coverage other than through employment and because the benefit structures are closest to products already sold in that market. Although large em-

ployers can certainly be faulted for not pursuing innovations aggressively enough, replacing health benefits from large employers with individual purchasing could cut off a lot of the potential for innovation.”

“Policymakers should be spending their energy today on developing viable structures, such as insurance exchanges, that have the promise of offering and distributing individual coverage efficiently and with sufficient pooling that it is accessible to the broad population without access to employer-based coverage, including those with low incomes who will be subsidized under a possible program of universal coverage. The experience with a reformed individual market should then be evaluated to make a judgment down the road about whether it should be expanded to replace employer-based coverage.”

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## Rural Innovation & Cooperation

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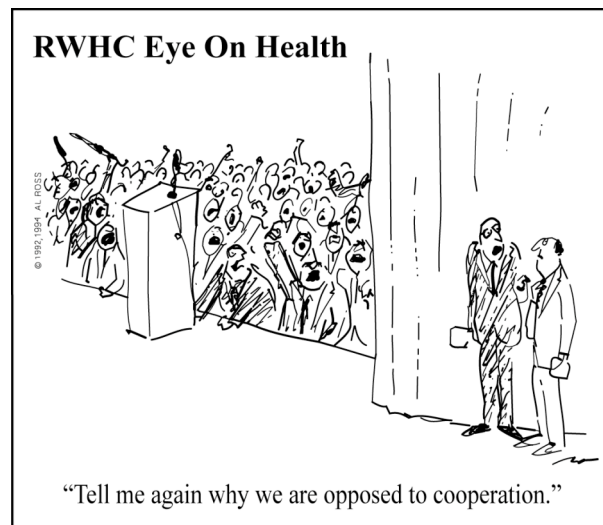
From “The North Dakota Experience: Achieving High-Performance Health Care Through Rural Innovation and Cooperation” by McCarthy, Nuzum, Mika, Wrenn, & Wakefield, a *Commonwealth Fund Report*, 5/15/08 at <http://www.commonwealthfund.org/>

“Resource constraints and the desire to preserve the local economy have made necessity the mother of invention in North Dakota, driving health care providers and policymakers to try new approaches to care and to institute better practices relatively quickly. Collaboration to support primary care and the concept of a medical home, organization of care through cooperative networks of providers, and innovative use of technology to meet patient needs and hold down costs are examples of how North Dakota is able to provide its citizens with accessible, quality, and efficient health care despite the challenges of a rural setting. Rural communities have a unique context of community trust and interdependence, a social capital that allows them to innovate in meeting patients’

needs. A strong sense of mission, vigilance to process and outcomes, and enhanced communication and collaboration among health care providers are key to improvements made in North Dakota health care.”

North Dakota not only represents a model for other rural areas facing physician and facility shortages, but may provide lessons that can be transferable to urban areas as well. For example, physician and pharmacist shortages are not exclusive to rural areas. In fact, the lack of trained providers at all levels is becoming a national problem. Greater use of telemedicine and enhanced roles for midlevel practitioners as part of primary care may be universally applicable both in rural and urban settings.”

“Rural communities have a unique context of community trust and interdependence, a social capital that allows them to innovate in ways that may be seen as too risky by their urban neighbors. Resource constraints have driven local providers to try new approaches to care and to institute better practices relatively quickly. Preserving the local economy by keeping dollars in the community has been another incentive. A flexible regulatory approach was key to North Dakota’s use of Telepharmacy to improve health care access in rural communities.”



“The North Dakota Telepharmacy Project raises a number of interesting policy questions. For example, should pharmacists with their advanced training and knowledge become more clinically oriented and turn over some routine dispensing and data entry duties to technicians? Why is the error rate lower in telepharmacies than in on-site pharmacies? Could pharmacists’ quality of life be enhanced if they practiced from

home or were employed by several stores simultaneously? Should regulations be changed to allow these and other technologic innovations in other areas?”

“Regionalization and networking of services seems to support improved efficiencies and patient outcomes. Increased efficiencies didn’t require centralization of

services. Rather, enhanced communication was key to the improvements achieved in site visit organizations through the use and enhancement of primary care, collaborative networks, and technology. A strong sense of mission and collaboration and constant vigilance to both process and outcomes also appear to be important for long-term success.”

“Policymakers considering the future for U.S. health care may take a cue from well-functioning rural health care systems such as those described in North Dakota, where providers regularly collaborate to improve services for patients and achieve outcomes that are often superior to the current high-cost systems elsewhere. To launch this new generation of medicine, the nation may have to learn more than just technique from rural areas. It may need to relearn what it means to be a community of neighbors. Meanwhile, those in rural areas have the opportunity to make rural health care even better than that received by those who live in urbanized areas, who must negotiate an often-fragmented delivery system, despite having greater resources.”

“Geographic isolation, resource shortages, and the desire to preserve the local economy have fostered creativity in North Dakota, driving local providers and policymakers to try new approaches to care and to institute better practices relatively quickly. Providers regularly collaborate with each other and with policymakers to improve services for patients and achieve outcomes that are often superior to high-cost systems elsewhere. Enhanced communication and collaboration, rather than centralization of services, seem to be the keys to quality and accessible health care in North Dakota.”

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## New Guide on Rural Leadership

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The Rural Assistance Center (RAC) has had added a new information guide on Leadership.

“Each RAC information guide focuses on rural aspects of an issue or topic. Guides include relevant information pulled from the news, funding and events sections of this web site, as well as links to useful publications and web sites. Some guides include in-

depth information, such as frequently asked questions and contacts for more assistance.” You can find this and many other guides with multiple resource links at:

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

*“We cannot solve our problems with the same thinking we used when we created them.”* Albert Einstein

“The need for strong leadership in rural America has never been greater. As our outlying communities struggle for survival - to provide quality healthcare, excellent school systems, workforce development and economic opportunities - quality leadership from those communities is the key. A rural community is only as strong as the individuals within.”

“Leadership means different things to different people, but fundamentally it is about making things happen that would not happen otherwise. Ordinary people in real-life situations willing to step forward, with the ability to learn and adapt, a commitment to excellence and quality, and able to acknowledge the strength of the local workforce, are so critically needed. Ensuring quality services, good schools, healthy economies and a strong workforce in our communities in the future takes quality leadership today.”

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## “There Oughta Be a Law”

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

I am at a meeting. Someone is saying that the problem is that the Temporary Assistance for Needy Families (TANF) rules allow the clients to choose their own day care providers. Their state, it turns out, offers voluntary licensure to day care providers but accepts the unlicensed as well, and TANF clients often select unlicensed providers. Really, this is a problem, someone says, and “there oughta be a law” to deal with it.

I’m listening to the discussion and trying to work out what the “problem” is. I understand the speaker’s basic point: that it would be a good thing if the TANF



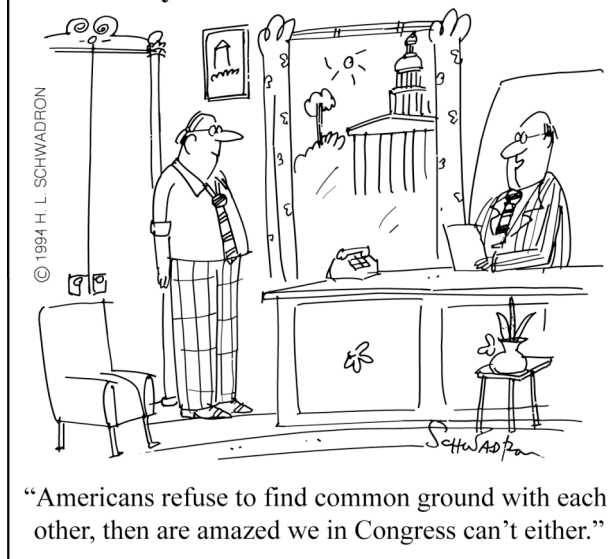
clients with whom she works would choose the better day care providers. It is unfortunate that the clients are free to make the wrong choices because often they use that freedom to do so. But what, I wonder, is the structural problem? What is it about Federal law, or State law, or the relationship between them that needs to be fixed to make this problem go away?

After some thought an answer comes to me. We need a system of government that lets us have it both ways: a system that will give us the freedom to choose for ourselves as well as a system that will ensure the right choices are made. Has there ever been a system like this? I remember the catechism lessons at the Catholic elementary school I attended. On the one hand, the sisters taught us, God had given us free will. We could make any choices we wanted to make. On the other hand, only one set of choices would lead us to heaven, and so they also taught us, in great detail, what the correct choices should be. You were, in effect, taught you must choose the “right” thing.

If we lived in a country where there was a universal consensus on what to do and how to do it, our lives would be like the life those good sisters tried to give to me. We would all learn to make the right choices and we would mostly make them. The few of us who did not would be subject to great social pressure. We do not live in a country like that. We have a constitution that divides the authority to govern between the Federal government and the State governments and envisions a separation of powers within the central government as well as between the Federal government and the States.

The balance of power between them fluctuates because it can be changed by laws passed by the Congresses whose members are elected by the voters. We have citizens whose views fall all along the political spectrum from a libertarian hands-off almost everything (on the far right) to a government that closely regulates and protects its citizens (on the far left). We

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also have citizens with widely disparate levels of education and experience as well as varied geographical and cultural differences. Given all this diversity, you can't expect that the effects of government will be consistent.

Emerson famously said that “a foolish consistency is the hobgoblin of little minds, adored by little statesmen and philosophers and divines.” Emerson used “foolish” as a modifier, condemning only a “foolish” consistency. There

seems to be a “close enough for government work” standard. There's nothing wrong with our system. If you want to have it your way, you only have to persuade the voters to agree. You can't expect the government to do your work for you.

If you think “there oughta be a law,” you need to line up some support.

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## RWHC '08 Rural Health Ambassador Awards

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The Rural Wisconsin Health Cooperative (RWHC) has announced their 2008 Rural Health Ambassador Awards to recognize health care employees at RWHC hospitals who have gone above the call of duty in promoting their respective organizations, while making significant contributions to rural health. Fourteen individuals from across the state received awards this year. Each recipient demonstrates a history of fostering positive communication and relations within the hospital's respective service area by: serving on community boards/service organizations; taking advantage of volunteer or public speaking opportunities; and supporting community health activities beyond the scope of the hospital. The 2007 RWHC Rural Health Ambassadors are:

**Theresa Braudt, RN—Boscobel**  
**Sue Peeler—Columbus**  
**Dr. John Lehman—Dodgeville**

**Dr. Scott Larson**—Hillsboro  
**Kathy Marose**—Mauston  
**Bev Hoege**—Reedsburg  
**Jane Greiling**—Richland Center  
**Brian Stephens**—Sturgeon Bay  
**Darla Wilson**—Tomah  
**Jon Myhre**—Viroqua

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## RWHC '08 Nurse Excellence Awards

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The recipients of the 2008 RWHC Nurse Excellence Awards are Beth Johnson from Stoughton Hospital for Excellence in Nursing Management, and Catherine Gende of Berlin Memorial Hospital for Excellence as a Staff Nurse.

The Nurse Excellence Award for Management winner, Beth Johnson, is employed as home health administrator at Stoughton Hospital where she has grown the department and provided organizational leadership for eight years. Beth is an active member of Stoughton Hospital's Leadership Development Team, collaborating with both internal and external leaders in the development of best practices for all clinical areas. In a recent all employee opinion survey, Beth received the second highest ranking as a manager, helping Stoughton Hospital achieve 97<sup>th</sup> percentile in overall satisfaction. She believes in shared governance, developing others, and empowering her staff members to strive for performance improvement. As a result, the hospital's Home Health Department was recently notified recognized as being in the top 25% of home care organizations for outcomes, performance improvement and financial performance. Beth is an active member of the Home Care Organization and belongs to the Wisconsin Organization of Nurse Executives. She is very dedicated to nursing education; contributing personally to scholarships provided by the nursing staff at Stoughton Hospital. Her contributions to health care are numerous. She is a nurse, a businesswoman, an exceptional leader, and very deserving of this award.

The Clinical Excellence Award Winner, Catherine (Katie) Gende, began her employment with Berlin Memorial Hospital twenty-five years ago. She currently works in the Intensive Care Unit and is a

member of the American Association of Critical Care Nurses. Katie graduated as an LPN in 1984 and subsequently completed the nursing program. In addition to her work in the ICU, she helps out in the Emergency Department and on the Medical/Surgical Unit. She is known for her clinical skills and caring for the most acute patients in the ICU. She has excellent assessment skills and is very respected by the physicians and her peers. Katie is especially good at patient teaching and uses her knowledge and warm sense of humor to make everyone around her feel comfortable. She is certified in Advanced Cardiac Life Support, Pediatric Advanced Life Support, and is qualified to insert PICC lines. Katie teaches nursing assistant classes for the local technical college and will be taking the Pediatric Advanced Life Support instructor course this spring. She serves as a preceptor for the Summer Nurse Intern program and helps with new employee orientation. Katie's colleagues say she deserves to be recognized because she has grown into a professional nurse who role models both the art and the science of nursing. They go on to say Katie gives the extra effort, tackles problems fearlessly and does so with humor.

The Nurse Excellence Awards were initiated 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.

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## Hospice Touch

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*Monthly, Eye On Health 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's feature is from Tomah Memorial Hospital, "Hospice Touch continues to leave mark":*

"Sonja McLaughlin is thankful Hospice Touch of Tomah Memorial Hospital saved her and her family.

The Adams County village of Arkdale teacher's aide said the she and her son were literally touched by an Angel after her husband lost a battle with cancer."

" 'We were devastated that no one could help us, but when Hospice came and when Valerie (Hospice Registered Nurse Valerie Kuehl) arrived at our door it was like an Angel was sent to us,' McLaughlin explained. 'They always gave us hope and encouraged us to pray and deal with each day.' "

"Even though the program has never generated enough revenue to cover the direct expenses associated with running it, Tomah Memorial Hospital continues to support it as an important component of the continuum of care offered to patients."

" 'As a non-profit, it's important for us to offer services because of community need, not because of the revenue they generate,' explained TMH Chief Financial Officer Joseph Zeps. 'With an annual budget of around \$1.4 million, Hospice Touch is one of the largest examples of this type at Tomah Memorial.' "

"Earlier this month, the hospital's Board of Directors approved the establishment of a permanent endowment to provide donors with a mechanism to make a gift that will continue to benefit individuals, families and community by providing financial assistance to Hospice Touch and its programs."



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" 'We established the program as a way to better reflect donor intent and allow for more planned giving in addition to the episodic giving that they enjoyed,' TMH Chief Executive Officer Phil Stuart said. "The program allows for planned giving and perpetuity for hospice and related programs."

"Hospice Touch provides end of life care through facilities in Tomah, Mauston and Adams-Friendship. The original program was formed in 1992. Annually it provides services to about 150 people, while touching the lives of hundreds more each year."

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