

Review & Commentary on Health Policy Issues for a Rural Perspective – November 1st, 2009

Reform Means Little Without Rural Access

From “Health Insurance for All is Necessary, but Not Sufficient, for Rural America” by Lynda Waddington at <http://iowaindependent.com/> on 10/14/09:

“The national health care reform debate has been dominated by issues like the public option, Medicare and Medicaid reimbursement rates and, unfortunately, too many distractions and misconceptions. Of all the open questions about moves to improve American health care, perhaps the only fact known for sure is that changes are afoot that would likely result in millions of uninsured Americans getting health insurance.”

“When Iowa Department of Public Health officials planned their health provider flu vaccinations, they learned that many Iowa providers were above the recommended age requirements to receive the live virus H1N1 vaccination. In fact, no providers in Van Buren County were below the cut off age of 49.”

“Expanding insurance coverage is important, experts say, but that is only half the battle. For many Americans, particularly in rural parts of the country, access to high quality health care services could remain elusive.”

“The main thing is to keep the main thing the main thing.” German Proverb
RWHC Eye On Health, 10/20/09

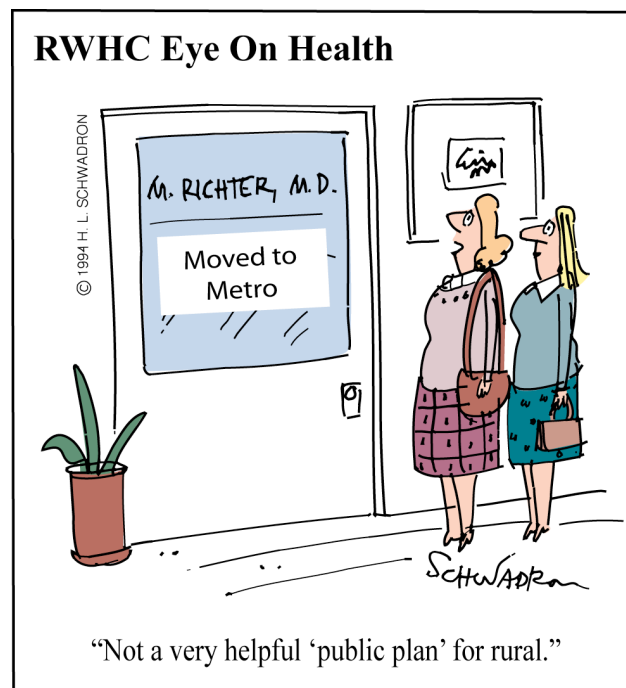
“ ‘We have some serious challenges in Iowa as it relates to the number of providers that we have,’ said Tom Newton, executive director of the Iowa Department of Public Health. ‘We do have a high percentage of our population that is insured at this time, and I would tell you that even some of them struggle right now to get access to health care. You can’t just assume that by providing people with a source of payment that you’ve provided them with access to health care.’ ”

“As previously reported, the Hawkeye State, like many other rural states, is coping with a plummeting number of health care professionals, including specialists, primary care physicians, nurses and behavioral health professionals.”

“While several factors such as perceived career stress and compensation issues are at the root of the decline, the problem is also being amplified by a rapidly aging health care workforce.”

“The alarming demographics and shrinking number of health care workers in rural areas are not just limited to primary care doctors. Other components of health care are also in short supply in much of Iowa.”

“ ‘We aren’t just talking about those people that are traditionally thought of as health care providers—it’s dentists, it’s mental health and it’s even pharmacy,’ said Cheryll Jones, a southeastern Iowa pediatric nurse



practitioner who serves on the board of the Iowa Rural Health Association. ‘There aren’t necessarily huge numbers of pharmacies in rural areas. So, even if you have a provider, you may have to travel a fair distance to get your prescription filled.’ ”

“ ‘[Workforce] is a concern that we have, and not just for rural, but especially for rural. Certainly, the need for folks to have health insurance is important, and that is where a lot of the focus has been, but access to insurance does not equate to access to care.’ ”

“A declining and aging workforce is probably the most publicly visible of the challenges facing a health care system, but it is far from the only challenge for rural areas. According to Tim Size, executive director of the Rural Wisconsin Health Cooperative, his state, like Iowa, maintains a relatively low uninsured rate.”

“ ‘We are very used to dealing with rural health in an environment where most people have insurance cards,’ Size said. “People having insurance cards is much better than people not having insurance cards, but it doesn’t deal with the long, long list of issues that we have to struggle with.’ ”

“As health care companies react to the current economic recession, there will be efforts to make health care services more centralized, which isn’t always in the best interest of rural consumers or providers.”

RWHC Eye On Health is the monthly newsletter of the 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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“ ‘We need collaborative ways for rural to work with rural and for rural to work with urban that maintains services available in the rural areas,’ Size said. ‘From that respect, we have to be very concerned about the economic incentives that will come with reform. ... There are a lot of models floating around out there that have tended to be developed in urban communities and we need to be very cautious about those being mandated into rural communities without any demonstrating or testing of the idea.’ ”

“When it comes to the debate over improving health care, Newton said, ‘It all comes down to how you define access.’ For many rural residents, the definition is likely to remain too narrow to make a difference.”

The Challenge of Healthy Rural Communities

As shown in the attached map of Wisconsin, it is critical to note that only 16 of 47 (2 out of 6) rural counties are ranked in the top half of health outcomes compared to 20 of 25 (5 out of 6) “metropolitan” counties. While rural healthcare can and does directly make a critical difference, individual health behaviors, jobs and income are also key drivers of our health. From “2008 Wisconsin Health County Health Rankings” at <http://uwphi.pophealth.wisc.edu/> on 10/16/09:

“The University of Wisconsin Population Health Institute is pleased to present the 2008 Wisconsin County Health Rankings. Now in its sixth year, the Rankings are designed to summarize the current health of the counties, as well as the distribution of key factors that determine future health. By taking a broad perspective on the factors that influence health—health care, health behaviors, socioeconomic factors, and the physical environment—we hope to encourage all community stakeholders to work with health departments and health care providers as partners in the public health system. We hope these new partnerships will serve to improve Wisconsin’s health, as well as provide a model for others to follow in monitoring population health.”

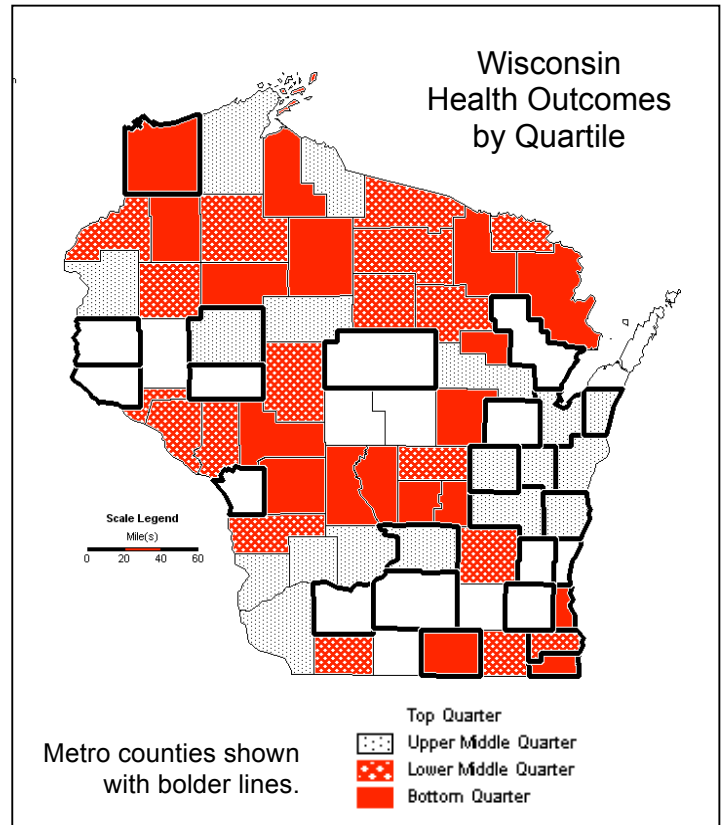
“The Rankings are based upon a model of population health in which health outcomes are considered the result of a set of health determinants and their distribu-

tion in the population. These determining factors and their outcomes may also be affected by policies or programs designed to alter their distribution in the community. Counties and cities can play a significant role in improving health through the adoption of appropriate programs and policies.”

“These health determinants are based on weighted scores of four major components: health care (10%), health behaviors (40%), socioeconomic factors (40%), and the physical environment (10%). The weights for the components are based upon a review of the literature and expert input, but represent just one way of combining these components.”

“To compile the Rankings, we have selected a number of population health determinants based on the health priorities of the Wisconsin state health plan, scientific relevance, importance, and availability of data at the county and city level. Many of the same measures are included in the Rankings each year but new measures are added as additional relevant sources of data are identified. This year the Rankings include Inpatient Quality of Care as a new measure in the Health Care category of determinants. For a detailed explanation of the choice of measures, see the 2008 Wisconsin County Health Rankings Full Report.”

“The summary of health outcomes rankings are based on an equal weighting of two measures: mortality and general health status. Premature Mortality is measured



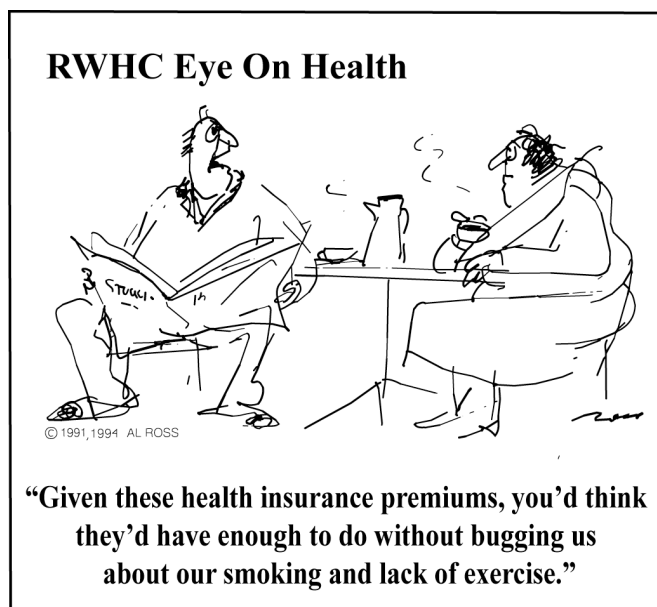
as years of potential life lost prior to age 75. General Health Status is measured as the percent of the population that reports fair or poor health (age adjusted).”

More Primary Care Necessary, Not Sufficient

From “Would Having More Primary Care Doctors Cut Health Spending Growth?” by Michael E. Chernew et al in *Health Affairs*, Sep/Oct 2009:

“Spending on health care in markets with a larger percentage of primary care physicians (PCPs) is lower at any point in time than is true in other markets. The relationship between physician workforce composition and the rate of spending growth is less clear. This analysis of market-level Medicare spending data reveals that the proportion of PCPs is not associated with spending growth. These findings suggest that changes in the composition of the physician workforce will not be sufficient to address spending growth.”

“Health spending in the United States varies greatly by geography; this fact is well known. For example, in



2003, age-, sex-, and race-adjusted spending for traditional Medicare was \$5,428 in the Minneapolis Hospital Referral Region (HRR) but \$11,422 per enrollee—more than twice the Minneapolis level—in the Miami HRR. These large differences are known to correlate with the ratio of primary care to specialist physicians in an area. Specifically, a higher proportion of primary care physicians (PCPs) has been shown to be associated not only with lower Medicare spending in a given year but also with higher-quality care.”

“In recent years a near-consensus has emerged that there are too few PCPs. Others have noted that improving access to primary care (and altering how primary care is financed) may help lower spending and increase the value of care provided in the U.S.”

“Although the evidence suggests a relationship between physician supply and health care spending at any point in time, the existing literature has not examined the relationship between the physician workforce and spending growth—a subject that may be of even greater concern than the high level of spending.”

“Our results in no way diminish the findings of previous studies. In particular, if one believes that the association between greater primary care availability and lower spending with similar health outcomes is causal, major efficiencies may be achieved by altering the composition of the physician workforce. These efficiencies may be an important source of savings for the system and delay the time when the system is no longer sustainable.”

“However, even if the proportion of PCPs were to rise and the relationship were causal, our results suggest that the ensuing efficiencies would represent one-time reductions in the level of spending and that subsequent spending growth would remain a concern.”

Nobel Prize Affirms Cooperative Enterprise

From a press release, “Economic Governance: the Organization of Cooperation” for the Nobel Prize in Economics for 2009 to Elinor Ostrom “*for her analysis of economic governance, especially the commons.*”

“Elinor Ostrom has demonstrated how common property can be successfully managed by user associations. Oliver Williamson has developed a theory where business firms serve as structures for conflict resolution. Over the last three decades these seminal contributions have advanced economic governance research from the fringe to the forefront of scientific attention.”

“Economic transactions take place not only in markets, but also within firms, associations, households, and agencies. Whereas economic theory has comprehensively illuminated the virtues and limitations of markets, it has traditionally paid less attention to other institutional arrangements. The research of Elinor Ostrom and Oliver Williamson demonstrates that economic analysis can shed light on most forms of social organization.”

“Elinor Ostrom has challenged the conventional wisdom that common property is poorly managed and should be either regulated by central authorities or privatized. Based on numerous studies of user-managed fish stocks, pastures, woods, lakes, and groundwater basins, Ostrom concludes that the outcomes are, more often than not, better than predicted by standard theories. She observes that resource users frequently develop sophisticated mechanisms for decision-making and rule enforcement to handle conflicts of interest, and she characterizes the rules that promote successful outcomes.”

Learning Rural Health Leadership

Below is from Jo Anne Preston, Workforce and Organizational Development Manager at RWHC; contact her at jpreston@rwhc.com for more information about leadership development workshops:

The set of skills needed to be a great leader are a different set of skills than it takes to be great in one’s chosen technical field. This seems obvious, but so often we take someone who is a great nurse, lab tech, physical therapist, etc. and make them a leader of a team, then wonder why they struggle in the new role.

Without the benefit of concentrated skill development, new leaders become frustrated and often fall into common traps:



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- Being perceived as treating people differently, playing favorites with old friends, and straddling the fence between being a manager and front line employee
- Burning out by doing the work of their old job because that is what they know
- Working hard, but not seeing any measurable results in important areas such as communication, conflict, team building, etc.
- Avoiding the difficult conversations, with the end result of employees seeing the leader as ineffective, developing morale issues, i.e., “there’s no point in saying anything, nothing ever changes anyway”, and the loss of respect that comes with that
- Inexperienced hiring, which results in mis-hires and the cost of re-recruitment
- Going over budget, being unprepared for capital expenses that should have been anticipated or just avoiding the finance aspect of the role to the detriment of themselves and their department
- Starting initiatives that fizzle, and over the course of time developing a resignation about change efforts that don’t ever seem to amount to anything lasting
- In a nutshell, new leaders feeling incompetent, anxious and afraid they made the wrong decision to become a leader

While thousands of books on leadership ponder theoretically whether leaders are born or made, clearly there are some skills that can be learned. It not only makes the leader more successful in their role, but they get to results quicker and thus experience less stress on the way when they master the basics of managing and leading. Quicker and better results plus less anxiety = more confidence, competence and better retention. **What can new managers learn that will really help them?**

1. How to **navigate the change in relationships from being a peer to being a leader**: many people drawn to work in health care are relational people. If the relationships are not “right”, stress increases and job satisfaction goes down. For many leaders, the people they went to lunch with daily now see the new leader as “one of them”-them being “*management*”. New leaders can learn how to deal with the mixed feelings that come with the promotion, set clear boundaries, communicate more clearly for buy in and respect and fully accept their new role.
2. How to **handle underperformance**: this is difficult for even seasoned managers. For the new manager, learning assertive communication skills, preparing and practicing for defensive responses from employees, identifying-in advance-their own hot buttons and tools to manage those and acquiring some basic templates and models for coaching employees will help them address rather than avoid the underperforming employee.
3. How to **set goals**: if their goals as a new manager are “improve teamwork in department, reduce conflict, have better communication”...they will not succeed. Setting goals that are specific, a stretch, measurable, achievable, relevant and timely will build the leader’s confidence because they are clear and unambiguous.
4. How to **interview and hire**: it’s not enough to have experienced being interviewed and hired, and HR can’t and shouldn’t do all the work in selecting the team. Successful hires start before the interview even happens with clarifying the job expectations, updating the job description, identifying the technical and performance aspects of the job, and then building consistent behavior based interview questions that will get you the answers you need to make the best fit.
5. **Basics of finance**: unless you are the finance manager, chances are that the basics of operating and capital budgeting, variances, profit and loss statements and how one’s department fits into the overall organization’s financial picture are murky territory. A good basic primer on finance terms, with local timely application and mentoring will elimi-

nate a lot of the fear that new managers have about this part of their leadership role. It also elevates the new leader's ability to see their department's role in the bigger picture of the organization.

6. **Leading a change effort:** leading change is a big part of why we need leaders. Change is great in many ways, especially if it is something we want. How does a new manager lead a change that either they don't agree with or know that their employees will resist? A new leader equipped with the fundamental, functioning components of change and the communication techniques to address resistance will get better, more focused results than a leader who just understands that there will be a lot of change.
7. **Delegating:** new leaders are fresh from the "doer" mentality, where the more they individually produce, the better they feel and the more reward they receive. Now their job is to help others produce; how does that work? The lure of doing the old job for the satisfaction it offers can be a trap not only in terms of time management, but the lost opportunity-and responsibility -to grow and develop others. New leaders can learn the why, how, when and who of delegation through tools that will get them there quicker than a vague expectation that they just need to "delegate".

New in a job, people want to know what is expected of them, and to have the tools and resources necessary to succeed. Development opportunities exist for all of these skills and are worth the investment early in a new leader's career.

Rural Hospitals Drill Down into Service Costs

RWHC is actively encouraging rural hospitals to give *Express View*® a close look. This interview with a RWHC member executive is from "Express View Costing: Using Advanced Cost Modeling to Change Your Management Culture;" it was downloaded from http://www.wipfli.com/InsightDetail_HC_ExpressViewCosting.aspx on 10/16/09:

"In his thought provoking article "The Cost Conundrum" (*The New Yorker*, June 2009), author Atul Gawande reminds readers of our lawmakers' aim to 'bring (health care) costs under control.' Later on, the author concludes that few hospital executives have anything more than a vague notion of whether their organizations and providers are more or less efficient than their counterparts elsewhere."

"Many hospitals, especially in recent years, have focused on transforming patient care processes to improve the individual patient's safety and satisfaction (Transformational phase) while targeting greater overall quality. Typically, these efforts have focused both on culture change and on process improvement, ultimately crossing functional department boundaries to focus on improving customer and quality processes throughout the entire episode of care."

"Unfortunately, when it comes to understanding costs through these same processes and care episodes, most hospitals are very much lagging (Functionally driven phase). They still rely heavily on a view of costs based upon the traditional department 'silos' and are unable to effectively assert unit costs at the patient or service level. The unintended outcome is that no individual or team is accountable for the costs of care because no one can fathom the impact on costs of the care decisions being made."

"Vernon Memorial Healthcare (VMH), located in Viroqua, Wisconsin, is among the few community hospitals that have moved forward in understanding the costs of patient care processes and episodes of care. For several years, VMH has utilized *Express View*® cost modeling to identify key insights about the costs of its patient care processes. Mary Koenig, CFO, recently visited with Wipfli's Mike Scott to discuss the transforming impact that using *Express View* has had on VMH."

"[Wipfli] You have been a user of *Express View* for nearly four years. Prior to *Express View*, did you have a method or process for developing costs and evaluating profitability and, if so, can you describe that method or process? [Koenig] We used a variety of different methods for estimating cost, mostly without much success. Most of these efforts focused on departmental costs, not cost per procedure, cost per patient, or service line cost. We used

the cost-to-charge ratios from the Medicare cost report and information from our general ledger. Nothing was able to give us the true, fully allocated cost of a certain DRG, diagnosis, or procedure. We also did not have a good way of determining net revenue by patient type. We used the payer mix by department to estimate net revenue by department but could not take it to the procedure or patient level.”

“[Wipfli] What initially caused you to search for a different solution? [Koenig] There have always been questions such as ‘What does it cost to provide XYZ service?’ It has always bothered me that we could not truly provide an accurate, reliable answer to such questions. Being a small hospital, we didn’t feel we could afford to invest in an elaborate cost accounting system. In addition, our most recent strategic plan calls for expansion of our orthopedic and general surgery service lines. In order to get a true picture of the profitability of these and other services, it is essential to know what the costs really are. *Express View* offers an affordable means of accurately measuring the cost and profitability of the services we provide.”

“[Wipfli] How did the management team initially view the information and model results contained in your first model? [Koenig] I would say cautiously. There was a lot of information to digest. We wanted to make sure we understood exactly how costs were developed in the model. Once we were comfortable with it, we were pleased with the type of information we could obtain and definitely surprised by some of the initial findings.”

“[Wipfli] Your CEO once stated ‘This will be an awakening for our managers.’ Did your senior team react quickly and decisively after seeing and understanding the model results? [Koenig] Some of our managers quickly realized how valuable the model data can be for decision making. For example, our surgery manager realized early on that the cost of supplies for the orthopedic surgeries we do here is a much larger percentage of the total cost of these procedures than she believed it to be. This inspired her to approach the primary vendor for additional price re-

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www.ruraladvocate.org/

ductions on our large volume implants. Also, after looking at the profitability by payer for the procedures we perform, the orthopedic service line planning group has decided to pursue expansion of our marketing efforts into other geographic areas.”

“[Wipfli] What have been some of the significant changes or improvements you have made using more accurate cost data (process and quality improvement, service line improvement, market expansion, financial performance, and customer satisfaction)? [Koenig] Data from the cost model has facilitated a realistic evaluation of the services we provide. In our orthopedic service line planning effort, one of our goals is to decrease the cost per case. We used data from our 2008 cost model to measure profitability by patient and payer at the start of the planning effort. During 2009, changes were made to streamline the processes used in caring for our orthopedic patients. Once we have the 2009 cost model data, we will be able to determine if we have been able to achieve our goal of reducing the total cost per case.”

“[Wipfli] Has the use of more accurate cost information had an effect on your management team with regard to their strategic views and ability to leverage the strategic cost information? [Koenig] We now know that if we are contemplating expansion or contraction of a certain service, we have solid cost and profitability data to support our decision. In our orthopedic service line planning group, we have been able to easily evaluate the profitability of the procedures we provide and answer many other strategic questions—what if we increase market share, how much additional volume can we add without increasing staff and facilities, what would happen to profitability if a new procedure was added to the service line? By focusing on profitability by patient and service line, instead of departmental profitability, staff from the various departments have been able to work together more cohesively with much less defensiveness.”

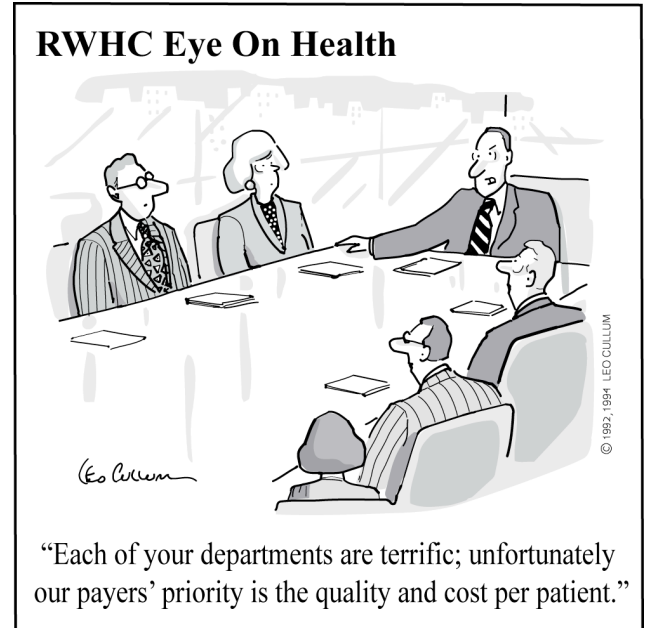
“[Wipfli] Has there been any change to your management processes (i.e., budgeting or strategic

planning) since your organization integrated annual cost data into your decision support information? [Koenig] So far, the impact has been mainly on our strategic planning process. Data from the model has been used extensively in our service line planning activities. The data gives us a clear picture of which diagnoses, procedures, and payers are profitable or unprofitable and helps us to plan our future growth.”

“[Wipfli] What role do you see the cost model playing in the future? [Koenig] We will continue to use the cost model to evaluate cost and profitability of the services we provide now or hope to provide in the future. I can see us using the model more extensively in our budgeting process and also in pricing. With accurate cost and margin data, it will be possible to establish prices that will stand up to the increasing scrutiny of patients and payers. Budgeting will also be facilitated by having accurate cost data. Once we have volume estimates, we can plug in net revenue and costs using data from the model. We can then easily tell what effect a change in procedure volumes will have on our budget.”

“[Wipfli] What were the factors that led you to choose *Express View*? [Koenig] We have had an ex-

cellent, long-term relationship with Wipfli for consulting and auditing services. We knew we could trust them to provide high quality, reliable service and support. The cost of the *Express View* system is affordable for small hospitals and the system does not require a big time commitment from our staff to implement and maintain.”



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