

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

Medicare Cuts Tax Rural Communities

by Tim Size, RWHC Executive Director

There is no question that Washington must get its house in order. We owe that to our children and our grandchildren. But the recent “debt ceiling deal” breaks the oldest rule in medicine. “First, do no harm.”

We all are at risk from those politicians more concerned about looking tough than solving our country’s problems. Medicare and Medicaid are on the chopping block, but it is not just the elderly and poor who may be harmed.

Washington has created a new “super committee” to find more cuts. Some call it a super Congress to remind us this is a small group given powers usually kept by Congress. Most economists say Washington needs a coherent policy for both additional cuts and additional revenue. But politics seem to have taken new revenue off the table. Most people believe the super committee will deadlock.

If Congress fails to act, cuts will be implemented across the board. Most federal programs will be cut. Across the board cuts harm efficient programs along with the inefficient. Across the board cuts harm necessary along with the less necessary. **The country deserves better than bulldozers driven by blind-folded drivers.**

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 market place 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 eventually closure.

RWHC Eye On Health



“The voters like your hard line but are starting to figure out that it means their jobs.”

A national study from the University of North Carolina in 2006 showed that in communities with just one hospital, its closure reduces average per-capita income by 4 percent. Local unemployment rates were also shown to go up by nearly two percentage points. Both effects are due to the loss of hospital jobs and local purchasing as well as the downstream economic impact of those losses.

Bottom line: closing a rural hospital has the economic impact of a 4% tax increase.

When a community loses its hospital, it is also at high risk to lose physicians. But it is just not patients who lose. According to the Federal Office of Rural Health, each primary care physician lost means the loss of 23 other local jobs.

Does any of this save the federal government money? Not likely. If a rural hospital is forced to close, Medicare and Medicaid will continue to pay for part of the health care. They just don’t pay in the rural community. Patients are forced to travel to urban hospitals. Local jobs soon follow. Urban hospitals will spread their

costs over more patients. But the federal deficit is largely unaffected.

So what is to be done? Rural hospitals expect the federal government to hold us accountable, like any payer. We understand that to do it better, we will have to work harder and smarter.

We can reduce rural hospitals' share of the debt by following the Triple Aim long promoted by the non-partisan Institute of Health Improvement. "Improve the health of the population; enhance the patient experience of care (including quality, access, and reliability); and reduce, or at least control, the per capita cost of care."

Congress needs to stop the bomb throwing. Congress needs to start the hard work of finding common ground for our country's problems. We need government that works with rural hospitals to serve America's older, poorer and less healthy communities.

Ron Kind Shows Off Wisconsin to CMS Chief

From "CMS's Berwick, Rep. Kind Listen, Learn from Wisconsin Health Care Leaders" in *The Valued Voice* from the Wisconsin Hospital Association, 8/19/11:

Prior to the rural health care roundtable meeting, RWHC compiled a comprehensive list of rural CMS issues that was shared with Berwick. The compendium can be found online at: www.RWHC.com

"After holding listening sessions with more than 300 hospital executives, nurses and physicians in attendance from three western Wisconsin communities, Centers for Medicare & Medicaid Services (CMS) Administrator Don Berwick, MD, was obviously impressed by what he heard."

" 'You have a diamond mine in the Midwest,' said Berwick. 'People can learn a lot from Wisconsin.' "

"Berwick confirmed what providers know as fact—the Wisconsin health care delivery system continues to be a model for the rest of the nation in terms of providing

high quality, low cost patient care. Berwick was joined by Representative Ron Kind at listening sessions held August 18 in La Crosse, Eau Claire, and Black River Falls. Congressman Kind was equally impressed by what he heard."

" 'Our hospitals and clinics have long been providing the kind of high quality low cost care that the rest of the nation should be looking to as a model,' said Rep. Kind. 'Updating our delivery systems nationwide, to produce care focused on outcomes instead of volume, is the only way to get our health care costs under control in the long run. I am pleased that Dr. Berwick was able to tour and visit these high-performing facilities and meet with the committed providers that consistently deliver some of the best, most coordinated care in the country.' "

"Stan Gaynor, president and CEO of Black River Memorial Hospital, hosted the rural health care roundtable held in Black River Falls, where Wisconsin Hospital Association Senior Vice President Brian Potter was in attendance, along with Tim Size, executive director of the Rural Wisconsin Health Cooperative (RWHC). They were joined by about 30 hospital CEOs and other administrative and physician leaders from several western and southern Wisconsin facilities, along with staff from the Wisconsin Medical Society, and Dean Robert Golden, MD, from the Wisconsin School of Medicine and Public Health."

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.

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Blogs: www.ruraladvocate.org/ www.worh.org/hit/

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“Congressman Kind opened the Black River Falls listening session by discussing the challenges of health care reform. He stated the status quo is not sustainable, and delivery and payment reforms are necessary to improve the quality and access of health care in rural and urban areas across the country.”

“In his opening remarks to the group, Berwick mentioned since the day he started at CMS, rural health issues have been front and center for him. He told the group his father was a rural physician, and he is well aware of the many challenges rural providers face.”

“He went on to say the big challenge CMS has is to extend coverage with limited resources. That means the health care system needs to be reorganized to reward value instead of volume. Coordination, integration and community involvement are three key components to help facilitate this change.”

“During the roughly 60-minute session in Black River Falls, Berwick and Congressman Kind heard concerns, comments and questions on subjects ranging from issues surrounding the ACO rules and the potential impact on the future of rural independent providers, the role of CMS in providing better information to help providers facilitate change, liability reform, workforce shortage issues, administrative simplification, 340B drug program, and the challenges of providing long-term, home health, and end-of-life care.”

“Berwick ended the session by thanking the group for their input. He stressed CMS needs professional leadership from providers like those in the room to help facilitate the changes needed to improve the system. He encouraged the group to continue to come forward with ideas and committed to make CMS a better support system and resource for change.”

“ ‘Wisconsin providers are at the leading edge of innovation and efficiency,’ Potter said. ‘Meetings like this provide a forum for showcasing Wisconsin’s leadership in providing high quality, accessible and affordable health care.’ ”

Rural Hospitals: Hubs for Rural Health Care

While the following article focuses on Critical Access Hospitals (CAHs), the opportunities and challenges noted also apply to small rural hospitals that are not CAHs but equally well serve their local communities.

From “Critical Access Hospitals: Hubs for Rural Health Care” by Mark Schoenbaum, in *Minnesota Medicine*, 9/11, with the complete article available at www.minnesotamedicine.com:

“Following Medicare’s adoption of a prospective payment system in the 1980s, a system by which Medicare reimburses hospitals for inpatient services based on a predetermined rate for treatment of a specific illness, 23 rural Minnesota hospitals closed, causing thousands of area residents to have to travel farther for emergency and basic care. It was not possible for these low-volume hospitals to cover their fixed costs under the prospective payment system. Responding to similar trends nationally, Congress created a new type of rural hospital designation, the Critical Access Hospital (CAH), as part of the 1997 Medicare law.”

“The provision allows small rural hospitals to receive cost-based reimbursement on their Medicare business in return for limiting their bed count to 25, maintaining an average annual inpatient length of stay of four days, and offering 24-hour emergency care services. Becoming a CAH brings a facility an average of \$850,000 in additional Medicare revenue a year.”

“The CAH program has helped those facilities become financially stable and keep their doors open, thus preserving access to care for an estimated 950,000 people in the state. This article looks at how CAHs in Minnesota are serving their communities as well as some of the challenges they face.”

RWHC Social Networking Resources

Website: www.rwhc.com  : [RWHC](https://twitter.com/RWHC)  : [RWHC](https://www.facebook.com/RWHC)
Blog: Rural Health Advocate: www.ruraladvocate.org/
Blog: Rural Health IT: www.worh.org/hit/

Access to Physicians—

“The financial stability provided by a CAH designation has lent support to primary care providers in many communities. In some, the physician prac-

tice has become part of the hospital, which can offer more substantial infrastructure and support systems. This has helped communities retain physicians who might otherwise struggle with feelings of professional isolation and to keep up with the rapid pace of change in health care delivery. In addition to offering primary care services on their campuses, CAHs often operate clinics in neighboring communities that might otherwise be too small to support an independent clinic.”

Care Coordination—“That CAHs often share staff with primary care clinics, nursing homes, home care agencies, and other services gives them experience with care coordination. Thus, CAHs tend to do well with such critical aspects of care as discharge planning and collaboration across the continuum of care. This leads to improved quality, outcomes, and patient satisfaction. Improvements in these areas and reductions in hospital readmission rates are explicitly required in a number of the models created by federal and state health care reform legislation.”

Challenges—“Even though the 1997 law that created CAHs has helped a number of institutions survive and even grow and thrive, these hospitals face an array of challenges including maintaining financial stability, keeping up with changing technology, serving the needs of aging patients, and recruiting and retaining physicians and other providers. Changes required by reform legislation and payers and turbulent economic conditions will further test the agility of small hospitals with limited resources.”

“Demographic changes, especially the aging of the population, will continue to be felt more so in rural areas than in urban ones. The proportion of elderly patients CAHs serve is much greater than the state average. In addition, more CAH patients have chronic diseases and poorer health status than those treated in larger facilities. Poor health and the lack of public transportation also limit mobility for many patients served by Minnesota’s CAHs.”

“Another challenge CAHs will have to address is attracting surgeons, as there is currently a shortage of general surgeons, especially those trained for practice in rural areas. According to a recent Minnesota Rural Health Advisory Committee report, 21 percent of Minnesota’s general surgeons practice in rural areas, with only 7 percent working in the areas most likely to be served by CAHs. Surgeons are essential to rural health care, as they provide their communities with timely treatment for trauma, as well as procedures such as appendectomy, cholecystectomy, small and large bowel procedures, bariatric surgery, and hernia repair. General surgery is often a key to the financial viability of a CAH, as it is a major source of revenue. If a CAH is unable to offer surgical services, it may struggle to provide other services. The Rural Health Advisory Committee report includes recommendations to strengthen general surgery in Minnesota through additional rural-focused training, infrastructure investments, and changes in pre- and postsurgical care.”

RWHC Eye On Health



“The math is simple: Congress has a 12% approval rating; our local hospital has an 80% approval rating.”

EHR, but they have a lower rate of adoption than that of non-CAH hospitals, which is 96%. In addition, the EHRs used by CAHs tend to have less functionality and be less likely to achieve meaningful use core objectives. Health information technology will play a key supporting role in payment reform models such as accountable care organizations (ACOs), and the CAHs that are farthest along in adopting EHRs will be better equipped to participate in these ventures. Health care reform is presenting CAHs with other challenges as well.”

“Critical Access Hospitals have never operated in isolation. Under federal law, they are required to have a network agreement with at least one other hospital for patient referral and transfer. Many also participate in

networks for shared information technology services, group contracting and training, and joint clinical ventures. Historically, a number of CAHs have also been managed, leased, or owned by larger health systems, and there has been a noticeable uptick in the pace of system affiliation in recent years. In light of health care reform efforts, independent CAHs will not need to be acquired or disappear as long as they have mutually beneficial partnerships and connections to networks and care systems.”

Conclusion—“Whether they are independent or part of a larger system, CAHs will need to continue to reinvent themselves if they are to remain essential community institutions dedicated to improving health outcomes all along the care continuum—from primary care and prevention to trauma care. Although CAHs face the same uncertainties as other hospitals, they can serve as a model for other facilities and health care organizations as reforms and financial challenges force them to become more nimble and adapt to the changing needs of the populations they serve.”

Mark Schoenbaum is director of the Office of Rural Health and Primary Care at the Minnesota Department of Health.

We Need to Grow Our Own Physicians

This year, the Annual RWHC Monato Essay Prize awarded an additional prize of \$1,000 and Honorable Mention to Caitlin Rublee for “Addressing the Physician Shortage Epidemic One Shot at a Time.” Caitlin graduated in May 2011 with a Bachelor of Science degree in Biology from the University of Wisconsin-Madison. She will begin medical school in August at the University of Wisconsin School of Medicine and Public Health as a student in the Wisconsin Academy for Rural Medicine (WARM) program. For information on WARM go to www.med.wisc.edu/

Growing up in Park Falls, Wisconsin, in northern Price County provided her with a strong rural foundation, and for this reason, she looks to return to practice Family Medicine in a rural area. Her other interests include whitetail deer and turkey hunting, fishing,

scrapbooking, agate picking, and running. The following is from the complete essay available at www.RWHC.com:

“Programs and opportunities that introduce and ‘coach’ rural health to students so they can aspire to serve a rural community as a health care worker are essential. While the career possibilities in the healthcare field are numerous, I will focus on physicians. It is no mystery that rural areas are experiencing severe physician shortages, which is predicted to continue to increase in future years. In order to permanently begin to address these physician shortages in rural communities, we must commit to educating students from these areas at an early age on what defines rural health care and what it means to be a rural practitioner. It is, in my opinion, far easier than selling rural life to a licensed doctor not ever accustomed to rural culture and life.”

“Students must define and understand rural health to know if it would be an area they would enjoy working in. In Wisconsin I have heard people refer to rural as north of Highway 29, farm country, or anywhere not urban or metropolitan. From my experience, rural health is not defined by a specific definition but rather is reflected in the lifestyle and people.”

“Growing up in Park Falls, Wisconsin (population 2,793), the ‘Ruffed Grouse Capital of the World,’ had me located in the midst of 850,000 acres of national forest land with a 25-bed hospital. Living in this community containing the most remote hospital in Wisconsin has provided me with a unique perspective into what defines rural life and health. Rural is the smell of maple syrup cooking every spring, the beds of trilliums carpeting the woods, having a whitetail deer chase a black bear 10 feet in front of me while out jogging (and in that order!), calling back to a great-horned owl, witnessing a young bobcat on the front porch of my house eating bird suet, tractor rides, tamarack swamps, harvesting wild rice on a cool fall day, paying 20 cents more per gallon of gas than in suburban/urban areas, being willing to drive long distances, canceled school days due to extreme snowfall, vibrant maple leaf colors, the sounds of gnawing chainsaws, continued gunshots during whitetail deer hunting season, fresh hay being made, roosters crowing, picking 20 ticks off your pant legs, mosquitoes, and starry

nights. While this is by no means a complete listing, rural living is definitely more than spending an annual week-long vacation camping or snowmobiling near the woods.”

“My rural exposure and upbringing has helped develop my perspective on students in rural communities. I come from an average working family with the only history of a physician being my great-great grandfather, who—according to his obituary—walked through deep snow drifts to get to the houses of his patients over 100 years ago. Medicine as a career became the logical culmination of my varied interests and desire to be challenged. I have worked hard to initiate connections and find opportunities to solidify my decision throughout the years. Because of this path, I have learned much about what I would have found helpful and want to encourage other students. I have been thinking about my journey and an ideal system, if there could ever be such a thing. While students arrive at medicine as a career in many different ways, both direct and indirect, I would like to share my thoughts on how to ‘coach’ an interested student from an educational systems standpoint.”

“An ideal career education system would invite physicians and other healthcare workers to speak to students—beginning in elementary and at latest, middle school—as part of a career day. A tour of a local hospital or explanation of some of the instruments or procedures would further expose students to the career. Being open and honest about the challenges of rural medicine as a physician while offering a brief timeline of events necessary to reach the goal would give a sufficient introduction to capture the minds of truly interested students. Other students may later decide they would like to pursue such a career and remember this positive experience. Meanwhile, the students not interested in medicine receive a healthy dose of information about a community hospital, are exposed to a positive role model, and are encouraged to further their education after high school.

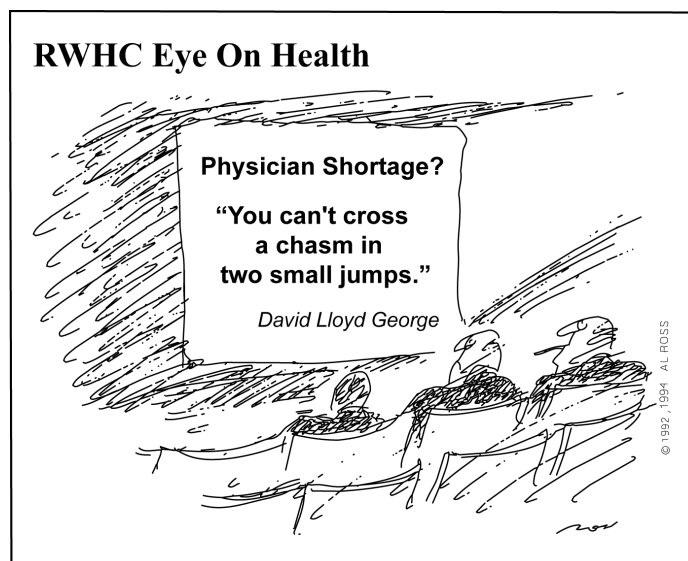
Even these students may transition to the health care field one day.”

“Students can then continue preparing academically for the rigors of medicine and the competition outside of a rural community setting. In academic exposure I would include dissection of organs such as whitetail deer hearts or pig kidneys and lungs. Availability of organs will vary among schools but a few creative options are available. During whitetail deer hunting season, students could bring in frozen deer hearts from a family harvest. Talking with a nearby butcher shop to save parts or working with the Wisconsin Department of Natural Resources (DNR) to obtain a large fish or animal to dissect would be great.”

“During college it is imperative for clinics, hospitals, research foundations, and education centers to offer rural observation time and internship opportunities to students with a keen interest in pursuing rural medicine. Research in Pennsylvania has shown an individual who grew up in a rural setting and who expressed a desire to practice family medicine at the start of medical school had a 36% chance of practicing in a rural area after finishing with medical school compared to the 7% chance of students without both criteria. Minnesota did a study demonstrating the effect of third year clinical rotations done in a set-

ting where ‘community teaching and preceptorship’ was heavily emphasized. The results showed 59% recruitment to rural areas compared to 18% of students not in such a setting. Although this data does not include the long-term retention rates of these physicians, I would argue that exposure in a rural clinic/hospital setting through internship and observation experiences in high school and at the undergraduate college level would increase the recruitment and retention of rural physicians to these areas.”

“Another motivating factor behind my decision to commit to rural medicine began with a newspaper ar-



title. When I am at school in Madison and read about my small hometown of Park Falls in the *Wisconsin State Journal* in not one but multiple articles, it really puts a personal perspective on the health profession shortages that are present. I remember reading the article ‘Life and Death in Park Falls’ in March 2010. This article discussed a head-on automobile collision of a couple traveling from Madison to Bayfield. The couple was rushed via ambulance to Flambeau Hospital, a Critical Access Hospital, in Park Falls. The nearest trauma center was in Marshfield 100 miles away.”

“The article continued by illustrating further obstacles to providing quality care in such remote settings. I read it and thought about how physician shortages and advocacy are going to be addressed if students from my generation do not commit to these rural communities. Rural citizens can talk about ‘brain drain’ in these areas but who is actively participating to address the concerns? Who is investing in their community’s students, especially after research shows that most students who return to rural areas after college are students who grew up in a similar setting? Some foreign physicians fill vacant slots and definitely play an integral role in providing care in these areas, but often times it is only for three years to obtain a visa and they move on. Where is the continuum of care so imperative to preventive medicine and long-term health?”

“On a final note, I would like to tell a story. One medical resident I worked with spent an entire morning teaching me about x-rays and CT scans. Although I am by no means proficient at reading them yet, I did familiarize myself with organs and was oriented to some of the major conclusions drawn from such diagnostic tests. After happily teaching me, the resident had me promise to help other students one day when I became a doctor. At that time I shrugged it off and said of course, although I was still far from believing in a medical school fate. Now, after I have secured a position in medical school, I will reply with a confident yes and urge others to do the same. For today’s students are tomorrow’s doctors. We need to plan for the future and it begins one student at a time, one shot at a time. Providing an opportunity of a lifetime. A role model. A voice that says, ‘You can do it.’ ”

Anti-Vaccine Movement Threatens Us All

Paul Offit’s new book, *Deadly Choices: How the Anti-Vaccine Movement Threatens Us All*, is reviewed by Kristen Audet, a Population Health Service Fellow with a two year placement at RWHC:

Paul Offit opens *Deadly Choices* with the assertion that Americans are engaged in a war. Indeed, Offit writes, “There’s a war going on out there—a quiet, deadly war.” But Offit’s work somewhat disproves this statement: the war is not quiet. Granted, one can choose to ignore the war, but for those with children, those who work in health care, and those who work in education, the war cannot be avoided and it should not be ignored. Daily, those individuals encounter The Issue: childhood vaccinations. Throughout his book, Offit demonstrates to his readers his subtitle: *how the anti-vaccine movement threatens us all*.

Offit scientifically disproves the “science” behind the anti-vaccine movement. For Offit to do this is not difficult because for the most part, the scientific case had already been well made. Offit presents arguments put forth by the anti-vaccine movement and then demonstrates how all too often they are clearly disproven not only by scientific study, but through the legal process: the claims have not held up in court. Through his considerations of the various fronts of this “war,” Offit leaves his readers with some major lessons:

1. Don’t believe everything you read. This is something most of us learned from our parents early on, but it is especially pertinent in the vaccination debate. There is a lot of bad science out there, misleading intelligent people everyday. Anyone can put anything on the Internet nowadays. Just because an organization has a webpage does not mean it is credible. When doing research about vaccinations, it is important to consider the source and its credentials.
2. Don’t believe everything you hear or see. Television and media outlets are not the best source for vaccination information. Media can be a good starting point for information, but you should always talk to your doctor if you are unsure about what is

best for you or your children. Further, while there can be mild side effects from vaccines, just because someone you know experiences that does not mean that it will happen to you or your child, or that those side effects are harmful.



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3. Trust: Offit's final chapter is titled "Trust." The concept of "trust" truly highlights both sides of his war, and illuminates the need for us as a community to trust in each other. He writes, *If we are to get past the constant barrage of misinformation based on mistrust, we have to set aside our cynicism about those who test, license, recommend, produce, and promote vaccines. Only then will we survive this detour-a detour that has caused far too many children to suffer needlessly.*

Reading Offit's work is both sad and encouraging. Reading his work, I was saddened by the masses of parents swayed by bad science, and saddened by the masses of children, as Offit puts it, in the middle of this war. Offit ends his book that he opened with an assertion, with a plea:

"Following the tragedy of September 11, 2001, there was a moment when we all stood still and looked at each other. No longer individuals, we were part of a whole. Personal interests were irrelevant. We were united in our grief. One. Then the moment was gone, dissolved in a cloud of lawsuits, finger-pointing, partisanship, and blame. But although fleeting, it had been there. And if we can recapture it-recapture the feeling that we are all in this together, all part of a large immunological cooperative- the growing tragedy of children dying from preventable infections can be avoided. We can do this. It's in us: the better angels of our nature."

It would do all of us well to step back and embrace our communal duty of protecting our nation's youth.

The Institute of Medicine has just released a report on the safety of vaccines, finding no link to autism, no link to Type I diabetes, and only very rare serious side effects. The complete report is at: <http://ow.ly/6jNRu>

Go to www.RWHC.com for info on the Southern Wisconsin Immunization Coalition or email questions to Kristen Audet at kaudet@rwhc.com.

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