

Review & Commentary on Health Policy Issues for a Rural Perspective – February 1st, 2006

Ten Enduring Ideas for Organizational Health

From “Our 10 Most Enduring Ideas” by Art Kleiner in *strategy+business* (*s+b*), published by Booz Allen Hamilton, Inc., 12/12/05; the complete survey and linked prior articles from *s+b* for each idea are available at <http://www.strategy-business.com> :

“From its inception *s+b* has been dedicated to the value and power of ideas. It has embodied the view that, as Victor Hugo once put it, ‘An invasion of armies can be resisted, but not an idea whose time has come.’ We like to think that our readers are real-world users of ideas, pragmatists who understand that a conceptual breakthrough can make enormous day-to-day difference.”

“For our 10th-anniversary issue we took the question head-on: of all the ideas *s+b* covered, which are most likely to endure for (at least) another 10 years? Here, are the winners—the ideas voted most likely to affect the way businesses are conducted in the long run:

1. Execution: It’s not your strategic choices that drive success, but how well you implement them. As Larry Bossidy and Ram Charan pointed out in their book *Execution*, the most critical quality for managers is the ability to put ideas into action.

2. The Learning Organization: A learning organization is one that is deliberately designed to encourage everyone in it to keep thinking, innovating, collaborating, talking candidly, improving their capabilities, making personal commitments to their collective future, and thereby increasing the firm’s long-term competitive advantage.

3. Corporate Values: Companies that care about ethics, trust, citizenship, and even meaning and spirituality in the workplace (or that simply articulate their values carefully) perform better in the marketplace than companies that care just about ‘making money.’

4. Customer Relationship Management: The cultivation of long-term relationships with customers, including awareness of their needs, leads to highly focused, capable companies. Over the last decade, *s+b* has singled out such customer-centric organizations as Snap-on Tools, Virgin Atlantic Airways, Apple Computer, Starbucks, and the Boston Red Sox (a mention of which cost this idea the vote of one Yankees fan).

5. Disruptive Technology: As Clayton Christensen noted in *The Innovator’s Dilemma*, technological innovation radi-

cally alters markets by undermining incumbent companies—which are vulnerable because their offerings are all tailored to the needs of their existing customers. Change feels like a betrayal of those customer rela-



“Think for yourselves and let others enjoy the privilege to do so too.” Voltaire

Contemporary Issues in Rural Healthcare

The first 2006 issue of the North Carolina Medical Journal, a Journal of health policy analysis and debate, will focus on "Contemporary Issues in Rural Healthcare." It is dedicated to **Jim Bernstein, the former Director of the North Carolina Office of Rural Health.** The issue can be downloaded without charge in February at <http://www.ncmedicaljournal.com>

tionships. Thus the makers of personal computers trumped Digital Equipment; Wal-Mart trumped Sears; and downloadable music is trumping the recording industry. 'You can be doing *everything* for your customer,' one reader wrote, 'and not see a market shift while it is occurring.'

6. Leadership Development: You don't have to rely on 'putting the right people in place.' You can train all employees to be better choosers, better strategists, better managers, and in the end, better leaders.

7. Organizational DNA: Leaders can design an organization's structures—incentives, decision rights, reporting relationships, and information flows—to induce high performance by aligning them with one another and the strategic goals of the enterprise.

8. Strategy-Based Transformation: Beyond reengineering, this is the redesign of processes and organizational structures, and the consequent cultural change, to fulfill the strategic goals of the enterprise.

9. Complexity Theory: Markets and businesses are complex systems that can't be controlled mechanisti-

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

Eye On Health Editor: Tim Size, RWHC
880 Independence Lane, PO Box 490
Sauk City, WI 53583

<mailto:office@rwhc.com> <http://www.rwhc.com>

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cally, but their emergent order can sometimes be anticipated. An understanding of the ways that complex systems evolve can help managers intervene and act more effectively.

10. Lean Thinking: This type of process and management innovation is exemplified by the Toyota production system. Employees use a heightened awareness of work flow and demand to cut waste, eliminate cost, boost quality, and customize mass production."

A Growing Threat to Hospital Mission

From "U.S. Hospitals: Mission Versus Market" in *Health Affairs*, Jan/Feb '06:

"In the 1990s managed care went to war against unsustainable hospital spending with selective contracting, utilization management, and discounts. Provider protests were often dismissed as self-interested whining, but thoughtful policymakers knew that as reimbursement shrank, there were legitimate reasons to worry about eroding cross-subsidies for teaching, research, charity care, and unprofitable services. Some of these worries were held at bay during an interlude when managed care weakened and hospital revenues bounced back. But resurgent health care costs and relentless budget pressure on Medicare and Medicaid reimbursement have renewed concerns about how hospitals' mission-driven activities will be supported."

"A new conceptual framework now surrounds discussion of this problem. A decade ago the health sector was viewed as having a brand of prodigality that was all its own—a system rendered insensitive to market forces by third-party payment and helpless against supply-induced demand because of an information chasm between buyers and sellers of care. Managed care and managed competition were solutions that were matched to the peculiar problems of the health sector—supplying respectively a check on provider-driven utilization and a framework for a functional market."

"In the new millennium, though, a more sweeping vision of the health economy's predicament is offered. Traditional health coverage, in this view, was a kind of

‘quasi-social insurance,’ which, by common consent, allowed cross-subsidies of uncompensated care, teaching, and other public needs in private as well as public financing arrangements. Now, in a deregulated, global, hypercompetitive economy, where Wal-Mart is a more typical employer than General Motors, price transparency and the elimination of all unnecessary supply-chain costs are the ruling imperatives. Conceptually, if not practically, the threat to hospitals’ mission-driven activities is greater than ever.”

Paying For Hospitals’ Community Service

From “Paying For Hospitals’ Community Service” by Bruce C. Vladeck (a senior health policy adviser, Health Sciences Advisory Services, at Ernst and Young LLP and a former administrator of HCFA, now the Centers for Medicare and Medicaid Services) in *Health Affairs*, Jan/Feb ‘06:

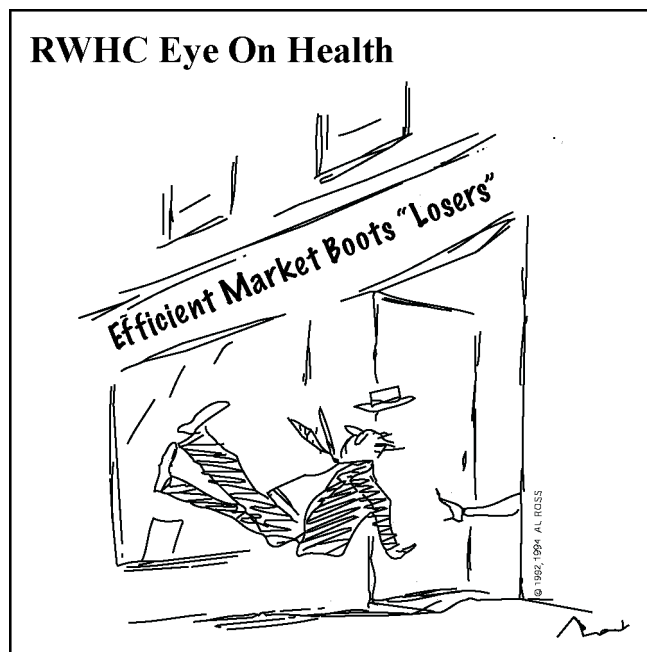
“U.S. hospitals incur costs of \$25–\$50 billion annually in providing ‘community service,’ primarily in the form of health professions education and standby costs. They also provide approximately \$30 billion in uncompensated care. Historically, such ‘community service’ costs have been subsidized explicitly by Medicare and implicitly in the prices paid by private payers. The sustainability of that system is highly uncertain. With a growing number of uninsured patients, allocating non-reimbursable costs to paying customers can create a ‘death spiral,’ in which fewer paying customers bear a larger proportion of such costs. The obvious solutions to this problem all have serious limitations.”

“Hospitals in the United States have engaged in internal cross-subsidization throughout their history, using surpluses obtained from more prosperous patients, philanthropy, or government to defray the costs of serv-

ices for which they were not paid. Rarely has that process been conducted with the degree of formality or neatness that would make life simpler for policy-makers or policy analysts; from the viewpoint of most hospital executives, money is, after all, fungible, and revenue is revenue. If all revenue exceeds all expenses, most are willing to stop there. As the economic environment in which hospitals operate becomes more demanding, however, hospitals might find it more difficult to generate surpluses from activities for which they are paid to subsidize activities for which they are not. The surpluses might shrink, or they might be absorbed in other activities, or both. Hospitals’ willingness or ability to provide non-paid-for services might therefore deteriorate. And, to the extent that those services are valuable to the hospitals’ communities, those communities will be worse off.”

Policy Options for Subsidizing Community Services—“Reflecting the importance of Graduate Medical Education in its health care system and its long tradition of relatively generous subsidization of health care for low-income people, New York State,

when it made the transition from a regulated all-payer rate-setting system, established a series of mandatory payer surcharges to finance medical education costs, uncompensated care, and a variety of other forms of community service identified by the legislature as important... In the current U.S. health care environment, New York State’s teetering system represents a kind of middle way among the policy options for subsidizing community service.”



“At one end of the spectrum is the system that prevails, de facto, in many parts of the United States: Subsidies for certain circumscribed components of community service are built into the Medicare inpatient payment system, and everyone else is on their own. As payments for patient care services come under increasing pressure, in a variety of forms, hospitals are increasingly hard pressed to sustain community-service activities. At the other end of the spec-

trum is direct public subsidization, independent of patient care reimbursement. This mechanism supports community service in a dwindling number of public hospitals and often suffers from the chronic under-financing of public services that is prevalent in many U.S. communities.”

“For hospitals without direct public subsidy, where Medicare DSH and GME and Medicaid DSH payments are serving primarily to cover shortfalls in Medicare and Medicaid patient service payments, the difficulty of generating revenue to support community service is compounded by increasing political and public relations pressures around the issues of tax exemption. Cross-sectionally, the magnitude of the implicit subsidies involved in the exemption of nonprofit hospitals from corporate income tax and, more important, local property taxes is increasingly identified as a potential ‘source’ of community service financing. But that doesn’t offer much comfort to hospitals that have never paid taxes as they scramble to generate operating margins large enough to maintain creditworthiness, so they can borrow the money to purchase the information technology that everyone tells them they need to acquire and the equipment they need to compete successfully with the entrepreneurial efforts of their own physicians. Tax-exemption, expectations about community service, and access to capital are all connected in a circle that hospital managers are finding increasingly difficult to square.”

“Therefore, as long as the problem of the uninsured goes unaddressed and the major payers, public and private, find themselves increasingly constrained from engaging in too much gratuitous generosity, it will be increasingly difficult for hospitals to maintain historical levels of community service activity, let alone to expand such activity to meet growing public demands. One example of the potential effects is contained in a recent report from the U.S. Centers for Disease Control and Prevention (CDC): While the number of visits to U.S. EDs increased 26 percent between 1993 and 2003, the number of hospitals operating EDs fell 12 percent. Increased waiting times and ambulance diversions were an almost inevitable result.”

Concluding Observations—“Although much of what has been lumped together in this paper under the rubric of ‘community service’ does not qualify as public goods in the strict, technical sense, hospital-

provided community service appears to resemble more classic public goods in at least one important way: **The more the financing of hospital care moves in the direction of a ‘perfect’ market, the less and less funding for community service there will be.** As long as hospitals retain strong pricing power in some markets, they will be able to extract sufficient surpluses from at least some payers to support valued non-patient care activity, but once that market power erodes, direct or indirect subsidies will be the only alternative. The current condition of the public financing programs suggests that that is not a very promising long-term alternative.”

“More generally, it is hard to see how adequate levels of community service can be sustained over time as long as the prevailing public philosophy insists that no one entity should be in charge of the health care system, or of the public’s health. To date, the continuing dynamism and creativity of U.S. hospitals, when combined with the ability of interests concerned with certain forms of community service to seek and find redress in public programs, and the weakness or obtuseness of many private payers, have supported many activities that are not sustainable in narrow economic terms. It’s not clear how long we’ll be able to continue to get away with that.”

Rural Health, the “Mouse” that Roared

From a press release “Congress Approves FY06 Appropriations Conference Agreement” by the National Rural Health Association (NRHA), 12/22/05:

“Congress has finally approved the second version of the FY06 Labor/HHS/Education appropriations conference agreement (HR 3010). The House passed it on December 14th. The Senate passed it by ‘unanimous consent’ so there was no roll call vote. While some critical rural health care funding was restored in this version of the bill, many valuable rural health programs were still cut or eliminated.”

“This was among the toughest appropriations fights that the rural health community has seen. NRHA members are to be congratulated for their impressive effort to let Capitol Hill know that rural health de-

serves better. We have heard from several Hill offices that their phones, faxes and emails were loaded with contacts from our members. We also heard that policymakers ‘underestimated the backlash’ that would result from making these cuts. Due to this incredible effort, rural health was one of the only areas that received any additional funding in this version of the bill. NRHA is very pleased that funding was restored to support the Federal Office of Rural Health Policy, the rural research centers, Rural Health Outreach Grants and the Area Health Education Centers. However the loss of funding for other very important programs for rural and underserved populations was a bitter loss for rural advocates.”

“Planning is already underway for the FY07 appropriations cycle and NRHA will once again be calling on you to act early and often. Please continue to be as responsive and helpful as you have been in the last several months. Keeping what we’ve got, and winning back what we lost, will require a consistent educational campaign and the NRHA’s success will always depend on the grassroots power of rural America.”

Rural Communities Address Meth Production

The East Tennessee State University College of Public and Allied Health is sponsoring the conference, A Community Approach to Address Substance Abuse including Methamphetamine Production and Use, in Appalachian and Rural Communities.

“Community teams of stakeholders affected by substance abuse issues are being recruited to attend. The conference is particularly targeted to Appalachian and rural areas. The two and one-half day conference will be in Johnson City, Tennessee on March 20-22nd.”

“Objectives and the framework for the conference were established by a group of Appalachian regional leaders at an assessment and planning workshop in August 2005. The series of seemingly never-ending difficulties identified to be caused by substance abuse moved participants to recommend a forum that would

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allow small communities time to learn from others and develop specific plans that involve and invest multiple stakeholders from the community. Teams are encouraged to draw representatives from public health, health and mental health providers, law enforcement and judicial officials, the media, environmental mitigation experts and other community leaders.”

“One objective of the conference is to enable communities to recognize the broader scope and issues that define substance abuse, including methamphetamine production and use. In addition to national and regional speakers, participants will share information about best practices by stakeholder groups and engage in skill building workshops. Each team will leave the conference with its own plan for strengthening efforts to understand and address specific aspects of substance abuse including methamphetamines in the context of their communities.”

“The Appalachian Regional Commission, the Federal Office of Rural Health Policy, the Southeast Public Health Training Center at the University of North Carolina and the East Tennessee State University College of Public and Allied Health, have provided funding to support the conference.”

For more info and team applications, see the conference website at <http://www.etsu.edu/methconference>

Changing Ageist Assumptions re Retirement

From “Sun setting later on some careers: More executives expected to keep working into 70s, 80s” by Bill Glauber in the *Milwaukee Journal Sentinel*, 1/16/06:

“The American boss of the future might look a lot like Dana Cable, Sr., who works 10 hours daily, worries over bills, meets customers and tinkers with inventions that won’t hit the market for years.”

“ ‘It’s still too much fun to work,’ says Dana Cable, so he continues to run Milwaukee-based Growing Systems Inc. even at 80. Business and demographic

experts say that as the population ages, more and more executives like Cable will stay on past the traditional retirement age of 65.”

“ ‘I know what I want—and it’s not going to Florida to retire,’ said Cable, president of Milwaukee-based Growing Systems Inc., which specializes in equipment for the production of young plants. Cable appears at the cusp of a potential trend—the graying of America’s business leaders.

Right now the trend is simply anecdotal, the likes of 75-year-old super investor Warren Buffett and 79-year-old football coach Joe Paterno showing younger colleagues a thing or two about how to succeed in business or sports.”

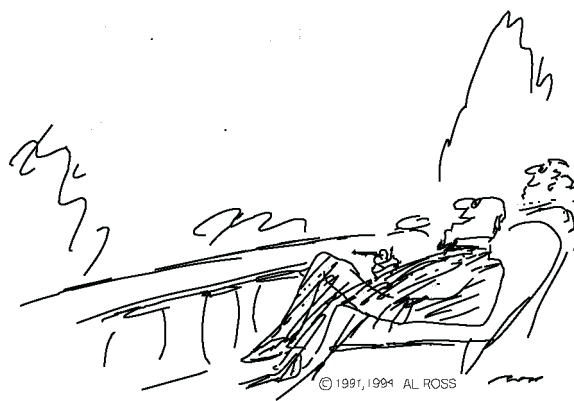
“As the country ages, though, more and more leaders in their 70s, 80s and perhaps beyond may remain on the job, their prime working years extended well beyond the traditional retirement age of 65. ‘It’s still too much fun to work,’ said Cable, who has an adding machine on his desk and a couple of rocking chairs in his office. The rockers are for visitors.”

“A few aging business giants already roam the landscape, including media moguls Rupert Murdoch, 74, chairman and CEO of News Corp., and Sumner Redstone, 82, executive chairman of the board and founder of Viacom, Inc.”

“In sports, Paterno and Florida State’s Bobby Bowden, 76, matched up in the recent Orange Bowl. The Buffalo Bills recently turned to an experienced hand to serve as general manager, 80-year-old Marv Levy, who said, ‘I’m old enough to know my limitations and I’m young enough to exceed them.’ In baseball, Frank Robinson, 70, will return for another season as manager of the Washington Nationals. ‘My mind is nowhere near retiring,’ Robinson testified last year before a U.S. Senate Special Committee on Aging. ‘I don’t think retiring is good for individuals.’ ”

“Demographics and the needs of both businesses and workers will drive trend to retain experienced bosses,

RWHC Eye On Health



“I’d retire except I’d miss the weekends.”

according to Tamara Erickson of the Concours Group, an advisory services firm. By 2030, nearly 20% of the U.S. population is projected to be 65 and older.”

“Older workers will want to work and remain active while businesses will need seniors to fill what Erickson said will be a looming shortage in skills and talent in the American workplace. ‘It’s going to be basically what the baby boomers want, the baby boomers

boomers will get,’ she said. ‘They’re not a generation of people who want to lie around in a hammock. They’re going to find a way to stay active as they move into the post-60 years.’ ‘Eighty isn’t 80 anymore,’ she said. ‘A lot of 80-year-olds don’t feel old and they feel like working.’ ”

“ ‘Right now, at least at the top business levels, the older boss is a niche player, and mandatory retirement remains in place in many corporate suites. There’s also a view in large corporations that top executive jobs are so demanding that older workers aren’t up to the challenge,’ said Peter Cappelli, management professor at the University of Pennsylvania.”

“ ‘In the 1950s, about a quarter of corporate executives died before they hit 65 so they died in office,’ Cappelli said. ‘There was a notion that you better get out by 65 if you want a retirement. Now, people are living longer and they’re living healthier. People don’t have to retire so they say the heck with it. You see these founding CEO-type folks hanging around forever.’ ”

“The Milwaukee area boasts a handful of prominent older executives. Baseball commissioner Bud Selig, 71, who presides over a multibillion-dollar industry, doesn’t plan to retire from the job until he’s 75. After that, he’ll teach and write.”

“ ‘I’ve watched many people that I know retire much too early,’ Selig said. ‘And I really do think in the end, to me, I can’t imagine getting up in the morning and not having something to do. Now, I have too much to do, but I’d rather have it that way. I’m a be-

liever that someone should work when they want to work and while their health enables them to work.’ ”

“George Dalton retired in 2000 as chairman and CEO of Brookfield-based Fiserv. He figured financial analysts half his age viewed him like they might view their fathers and realized it was time to get out. After Dalton left the company, he planned to shuttle between homes in Florida and Massachusetts and serve on some public and civic boards.”

“The plan lasted all of five months. Dalton, now 77, founded Call Solutions, which became NOVO 1 Inc., a firm that employs more than 2,000 people. ‘I really don’t work,’ he said. ‘If I had to work, I’d quit.’ ”

What Policies Support Rural Collaboration?

RWHC has received a one year grant from the Robert Wood Johnson Health & Society Scholars Program at the University of Wisconsin-Madison to address the question, “What Policies Encourage Local Collaboration for Population Health in Rural Communities?”

A central recommendation of the Institute of Medicine’s 2004 Report *Quality Through Collaboration: The Future Of Rural Health Care* is that rural communities must reorient their strategies from a “patient and provider-centric approach to one that also addresses the problems and needs of rural communities and populations, and... that rural communities, because of their smaller scale and other unique characteristics, offer an excellent setting for undertaking rapid-cycle change.”

This funding will support a UW graduate student to work with the RWHC Executive Director Tim Size, in cooperation with Wisconsin’s Rural Health Development Council (RHDC) to address a number of applied research questions such as:

- How can public, private and voluntary sectors most effectively promote the need for collaboration among rural medical, public health, and business partners to increase access to local preventive health services?

RWHC Rural Health Essay Competition 14th Annual \$1,000 Prize - April 15 Deadline

The Hermes Monato, Jr. Prize of \$1,000 is awarded annually for the best rural health paper. It is open to all students of the University of Wisconsin. Students are encouraged to write on a rural health topic for a regular class and then to submit a copy to the Rural Wisconsin Health Cooperative as an entry by April 15th. Previous award winners, judging criteria and submission information are available at:

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

- What is the existing evidence regarding the benefit of such collaborations to a rural community’s health status?
- What is the existing evidence regarding the benefit of such collaborations to rural community economic development?
- What is the existing evidence regarding the benefits to potential rural medical, public health, and business partners?
- What are “best practices” for rural community collaboratives focusing on preventive health.
- What are the advantages and disadvantages rural communities face, compared to urban communities when developing these multi-sector collaborative approaches?

The above applied research will help advance RHDC’s Strong Rural Communities Initiative to improve health indicators for rural communities in Wisconsin and significantly accelerate establishing collaboration for population health as the norm, not the exception, in rural Wisconsin.

RWHC Offering CAHPS Hospital Survey

RWHC will make the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program available to all small hospitals. The CAHPS Hospital Survey, a program of the U.S. Agency for Healthcare Research and Quality (AHRQ), is designed to collect patient satisfaction information from hospital inpa-

tients. CMS is requiring all vendors to use the same methods which are expected to produce a 40% response rate to the survey requests.

RWHC will be using the mail mode of surveying—two mailings, within prescribed timeframes, to each patient discharged from your hospital who meets the established criteria.

CMS has established a minimum of 300 completed surveys in a twelve month period for public reporting. However, they recognize that this may not be possible for some hospitals. Thus hospitals with a minimum of 100 completed surveys within a twelve month period will be publicly reported. For the purposes of achieving statistical significance, small hospitals are expected to survey all appropriate discharges in an effort to increase the number of completed surveys.

RWHC is focusing on keeping the participating hospital's workload at a minimum. The only hospital responsibility is to provide patient information to RWHC on a regular basis. RWHC will mail the surveys; track responses; mail follow-up surveys to non-

responders; upload data to CMS (as appropriate); provide participating hospitals with a response rate for their facility; and generate summary reports on a regular basis. Participants can use this information to drive their quality improvement programs. RWHC will also host regular teleconferences that will allow for sharing/networking on a variety of program related topics.

CMS is going to do a “dry run” of the CAHPS Hospital Survey and conduct user training sessions in early February. RWHC will be participating in the training since they are a vendor for this project. All hospitals who intend to participate in initial data collection for the survey must take part in the dry run for the first two months. The data collected during this period will not be publicly reported.

RWHC has developed a straight forward and financially efficient program for smaller, rural hospitals. The fees are very reasonable. RWHC also has an outpatient survey available, unrelated to the CAHPS Hospital Survey. ***For more information, please contact Mary Jon Hauge at 800-225-2531 or <mailto:mjhauge@rwhc.com>***

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