

Federal Support for Rural Hospitals?

The National Advisory Committee on Rural Health and Human Services (NACRHHS) is a 21-member citizens' panel of nationally recognized rural health experts that provides recommendations on rural issues to the Secretary of the Department of Health and Human Services. From "Implications of Proposed Changes to Rural Hospital Payment Designations Policy Brief," by the NACRHHS, 12/12:

Introduction—"In recent months, plans to restrict or abolish special Medicare payment designations for categories of rural hospitals have been proposed by a variety of groups, including the Congressional Budget Office (CBO), the Administration, and the Medicare Payment Advisory Commission (MedPAC)."

"The current system of differential designations for paying rural hospitals has worked effectively to address the inequities and instability which followed the 1983 Medicare hospital payment reforms. The Committee agrees with the groups proposing reforms that these enhanced payment designations could be more efficiently targeted than under current law. It is concerned, however, that some current cost-saving proposals do not appear to accomplish this result in the most equitable or harmless fashion."

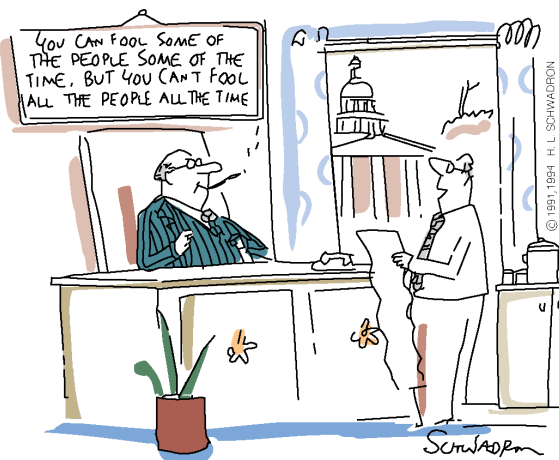
The Role of Small Rural Hospitals—"The patchwork system of protections created for rural hospitals since the mandated adoption of prospective payment by Medicare in 1983 has undoubtedly served an indispensable role in dramatically reducing the rate of closures among small rural hospitals. Many of these hospitals represent the sole access point to health care in their region, ensuring immediate delivery of urgently needed care and providing services that help retain physicians, pharmacies, clinics, and other health care resources in rural areas. Closure or relocation of a Critical Access Hospital (CAH)

has been observed to increase the difficulties rural communities already face in attracting and maintaining physicians and non-emergency health care services locally and providing timely access to emergency services. CAHs must deliver the same quality care under the same liability burden as urban hospitals, all with less capital and staffing on hand than are usually available among urban care facilities."

"Some CAHs cross-subsidize long-term care and manage

rural health clinics at their own financial risk because there may not be alternatives in the communities they serve. Thus, closure of the local CAH may have a profound effect on the availability of local health care services, both inpatient and outpatient. CAHs in particular are usually located in the least densely populated areas of the country—often among the highest shares of elderly and chronically ill patients—but all types of rural hospitals with special payment designations continue

RWHC Eye On Health



"The average rural beneficiary uses 3.7% less of the Medicare budget so it is obvious that rural hospitals are the problem."

to provide access to health care in medically high-need and underserved areas. Many of the benefits provided by these hospitals fall beyond the scope of traditional inpatient measures.”

“As of December 31, 2010, there were 1,316 CAHs across the country. Eighty-one percent of CAHs are located between 10 and 35 miles in driving distance from the nearest hospital—with an additional 4.2 percent within 10 miles from the nearest hospital—meaning that nearly all CAHs fall below the general 35-mile classification requirement and received their designation either through the 15-mile ‘secondary road or mountainous terrain’ or state-designated ‘necessary provider’ provisions. While CAHs constitute 52 percent of rural hospitals, a combination of Sole Community Hospitals (SCHs) (17 percent), Medicare Dependent Hospitals (MDHs) (8 percent), rural referral centers (7 percent), and standard Prospective Payment System (PPS) hospitals (16 percent) make up the remaining 48 percent of rural hospitals.”

“Although operating margins for rural hospitals have substantially improved since the 1980s, the financial health of these hospitals remains mixed. While more than three quarters of SCHs and rural referral centers operate profitably, only about half of MDHs, CAHs, and rural PPS hospitals have positive operating margins. These three types of hospitals also have narrower total margins on average than other rural hospitals. As hospitals that generally serve a larger proportion of elderly patients, MDHs and CAHs respectively charge 10 and 20 percent more inpatient days to Medicare than all other rural hospitals. CAHs also charge a far greater proportion of outpatient services to Medicare.”

“These numbers reflect the greater dependency of CAHs and MDHs on special federal payment structures, as well as the still fragile financial situations of CAHs, MDHs, and rural PPS hospitals. While some of these organizations are doing well enough to bring up the averages, many of them are losing money or managing to survive with thin margins. **This is an instance where using averages to justify reductions could cause widespread damage to these hospitals.**”

Rural Medicare Beneficiaries—“The people served by rural hospitals are more likely to report a fair to poor health status, suffer from chronic diseases, lack health insurance, and be heavier, older, and poorer than residents of urban areas. Yet overall, the average cost per Medicare beneficiary is 3.7 percent lower in rural areas than in urban areas, and rural hospitals perform better than urban hospitals on three out of the four cost and price efficiency measures on Medicare Cost Reports.”

Conclusion—“The Committee recognizes that potential exists to improve current rural health care infrastructure. **The concern is that the system as a whole is too fragile to sustain the type of sweeping cuts presently under discussion.** Revisions to payment designations must reflect a comprehensive and well-informed vision of the existing and desired health care systems in order to avoid a future rural economic and health care crisis. Although it shares the desire for a more efficient rural health care system, the Committee finds that the outlined cost-saving measures have not sufficiently consid-

ered the data and implications behind the proposals, nor articulated how the revisions will affect access to and delivery of rural health care.”

The complete text of this policy brief can be found at:
<http://www.hrsa.gov/advisorycommittees/rural/>.

Target States with Excess Spending

From “Taxation Without Representation,” by William B. Weeks in the Health Financial Management Association’s *HFM*, 3/13:

“Although the inexorable increases in healthcare costs are to blame for Medicare’s financial woes, certain parts of the country consume considerably more Medicare services than others.”

“For more than two decades, the Dartmouth Atlas Project has used small-area analysis to demonstrate geographic variation in Medicare expenditures. For example, in 2009, average age-, gender-, and race-adjusted Medicare Part A and Part B expenditures per beneficiary aged 65 to 99 varied by more than 60 percent, from \$6,763 in North Dakota to \$10,859 in Florida. That year, 10th percentile annual expenditures per Medicare beneficiary were \$7,240, 50th percentile expenditures were \$8,272, and average expenditures for the nation were \$9,021.”

“Thus, although taxpayers in North Dakota and Florida are subject to the same premiums and federal payroll tax rates to support Medicare, beneficiaries in Florida consumed services that cost about 60 percent more in 2009 than did those in North Dakota.”

“This finding is not an anomaly. There has been longstanding subsidy of high-consumption states by low-consumption states. Each year, during the period of 2003 through 2009, the average Medicare beneficiary who lived in North Dakota consumed \$2,119 less of Part A and Part B healthcare services than did the average U.S. Medicare beneficiary. Each year, on average, an average Medicare beneficiary living in Florida consumed \$999 more than the national average, and those living in New Jersey consumed \$1,267 more.”

“In essence, taxpayers in North Dakota subsidized health care received by Medicare beneficiaries living in Florida and New Jersey. In the aggregate, from 2003 through 2009, taxpayers in states that experienced lower-than-average Medicare expenditures subsidized \$71.9 billion worth of Medicare services for

patients in states that experienced higher than average Medicare expenditures. That subsidy represented a substantial proportion of total annual Medicare expenditures in a number of states: North Dakota’s subsidization represented 26 percent of average annual spending while New Jersey’s subsidy receipt represented 16 percent of average annual spending.”

“We already know the answer. In 2003, Elliott Fisher and colleagues found that additional Medicare con-

sumption was not associated with patients getting more care that they need (effective care, such as reperfusion within 12 hours of admission for a heart attack or getting an annual flu shot) or that they want (preference-sensitive care, such as knee replacement surgery or back surgery). **Higher Medicare consumption was associated with obtaining more supply-sensitive care, such as tests, X-rays, physician visits, hospital admissions, and days in inten-**

sive care. Higher spending was associated with higher risk-adjusted mortality rates and lower patient satisfaction.”

“In 2009, if high-utilization states had consumed the national average amount of care, Medicare Part A and Part B expenditures for patients aged 65 to 99 would have been about \$11.6 billion, or 4.9 percent, lower than they were; if the median reimbursement was achieved, cost savings would have increased to \$22.5 billion, or 9.5 percent of total Medicare Part A and Part B expenditures.”

“On its current course, healthcare expenditure growth will dwarf the problems represented by the impending, albeit delayed, fiscal cliff that the nation faces. Instead of temporary fixes, we need to create long-term solutions to solve a looming problem. But it might make sense to start where there is plenty of room for improvement: **States that have been the most profligate in their use of federal healthcare**

RWHC Eye On Health



“If Congress is so ready to take the scalpel to Medicare, they may want to first look at high-consumption states.”

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 in partnerships to make their communities healthier... generates additional revenue by services to non-Members... ongoing use of strategic alliances in pursuit of its Vision. Tim Size, Editor, 880 Independence Lane, Sauk City, WI 53583

www.RWHC.com



Email office@RWHC.com with *subscribe* on the subject line for a free e-subscription.

services should be expected to make the greatest reductions.”

Medicaid Expansion Good for Whole State

An Opinion, “Legislature needs to rethink Walker’s plan” from the *Post-Crescent*, 5/5/13:

“Though Gov. Scott Walker turned down expansion of the Medicaid health care insurance program for low-income people, two state health care organizations—the Wisconsin Medical Society and the Wisconsin Hospital Association—are urging him to reconsider.”

“This week, a Republican state senator, Alberta Darling, has asked the state to delay Walker’s plan. Walker and the Legislature should heed those concerns for several reasons, not the least of which is the health care of the people they represent.”

“The Medicaid expansion is part of the federal health care reform law. Under the U.S. Supreme Court’s ruling about the law, states have the option of whether to take up the federal government on its expansion offer. The feds say they’ll pay 100 percent of the costs of adding people who make up to 138 percent of the federal poverty level—a little more than \$30,000 a year for a family of four—for the next three years and 90 percent after that. The feds pay 60 percent of current Medicaid enrollees, with the state picking up the rest.”

“In Wisconsin’s version of Medicaid, BadgerCare, people up to 200 percent of the poverty level are covered, but there’s an enrollment cap, so some people are on a waiting list.”

“In rejecting the expansion plan, Walker instead said the state would eliminate the waiting list for people up to 100 percent of the poverty level—\$23,550 for a family of four—but stop providing health care coverage for those between 100 percent and 200 percent of the level. The state would add about 82,000 people, but drop about 87,000 people—a net loss of 5,000.”

“However, Walker points out, the people who are dropped will be eligible for health insurance through

the federal government’s new exchanges, which are supposed to be up and running by January. Under the health care reform law, premiums will be subsidized for low-income people, on a sliding scale.”

“So Walker meets two goals—fewer people will be dependent on the government for health care and more people will have health insurance. And, he and other Republicans aren’t convinced the feds will live up to their end of the deal on funding the expansion. But there are flaws in that plan, which brings up the hospitals’ and Darling’s concerns.”

“Both contend it’s unlikely that the exchanges will be ready in time. Enrollment is supposed to start in October and, even though the feds say they’ll be ready, it’s a massive undertaking. Darling is suggesting that the state take the extra funding for a year or so, until the exchanges are solidly established.”

“The hospitals are worried that the people who will eventually be dropped from BadgerCare—and Walker has said that won’t happen until the exchanges are set, even if there’s a delay—will either not get coverage from the exchanges because of confusion over them or not be able to afford coverage, even with a subsidy. Under the reform law, a family of four making about \$30,000 a year would face \$900 yearly premiums and cost sharing of up to \$4,000 a year. That’s pretty daunting.”

“The hospitals say more uninsured people will result in more uncompensated care, the cost of which they’ll have to eat or pass on to insured consumers. They’re no big fans of Medicaid because of its low reimbursement rates, but it’s better than nothing.”

“Hospitals and other health care advocates also argue that not accepting the Medicaid expansion will cost the state money. That’s true—the state will pay more under Walker’s plan than it would under a full expansion.”

“The hospital officials make a convincing argument. We share their concern about what will happen to the lowest-income people who will need to get insurances on the exchanges.”

“We also agree that the state can save money with a full expansion. If federal funding falls through in later

years, the state can opt out. Yes, that would mean dropping people from the program, which is politically difficult, but that's just what Walker's plan does now."

"So, if you're concerned about the state's budget, this is a good deal. If you're concerned about the effect Walker's plan may have on your health insurance costs because of uncompensated care, this is a good deal. And if you're concerned about fellow Wisconsin residents falling through the cracks of our health care system, this is a good deal."

"We urge legislators—Republican senators, in particular—to rethink Walker's proposal and pursue a plan that's best for the state, now and in the future."

How a Rural Hospital Gets in the Top Twenty

by Terry Brenny, CEO, Stoughton Hospital, Wisconsin

The National Rural Health Association (NRHA) recently announced the twenty critical access hospitals (CAHs) in the country that were ranked highest by their patients. The rankings were based on the hospital's performance as measured by iVantage Health Analytics tabulation of two Hospital Compare HCAHPS measures ("overall rating" and "highly recommend"). It was not a surprise to see RWHC Member Stoughton Hospital on the list so Stoughton's long time CEO, Terry Brenny, was invited to say what he thought accounted for their high performance:

"Stoughton Hospital has managed to achieve consistently high patient, physician, and employee satisfaction scores over the years due to our unwavering longstanding commitment to Excellence Together principles, the name adopted by our employees for our customer service program. We adopted and committed to Excellence Together seven years ago, and resolved the program should not be a 'fad of the month or one year experiment' but rather a sustained and hardwired philosophy that would become solidly

Support NRHA Rural Leadership Development

The National Rural Health Association has launched a permanent endowment **for programs that identify emerging leaders from and for rural communities**. The mission is to provide training and resources to help them play a lead role in ensuring access to quality health care for rural Americans.

Go to <http://ow.ly/ejmLf> to learn more.

ingrained and outlive its early adopters. A key reason the program is working is that while it was administratively inspired, the program is primarily employee driven with many employees

committed to it, and in effect driving the program. Our various component goals are created and measured by committees of employees who believe in it."

"We also continually remind ourselves that everyone must Walk the Talk including administration. As a simple example of that, administration has relinquished private, convenient parking spots near the building doors in order to provide these spots for customers, handicapped, etc. Actually, that proved to be no great sacrifice and we enjoy the easy exercise, opportunity to view and inspect the campus, relate with delightful customers and staff who are also walking to the doors. We are all expected to pick up litter, personally escort (or arrange for) customers who need to find a destination within our facilities. The homemade loaf of bread given to each discharged patient and follow-up calls seem to make a favorable impression as well. Many employees are solidly committed to community service projects such as Relay for Life, Heart Walk, Alzheimer's, Food pantries, Stoughton Wellness Coalition activities etc."

"Since pursuing excellence is a never ending journey (not a destination) we have resolved to develop a true relationship experience bonding with our patients and customers. That may be described as not only treating patients and customers professionally well, but developing a real, caring, trusting relationship with them which people instinctively desire and appreciate, but most importantly—deserve."

Physician Partnership and Formation

From a guest post by Sister Danielle Bonetti, VP Mission Integration with St. Mary's Healthcare, Amsterdam, New York, on Bill Bazan's blog at:

<http://medicineinsearchofmeaning.blogspot.com>

What is physician formation and why is it such an integral part in the practice of medicine?

“I think in these early days of developing the concept of ongoing physician formation both the concept and the implementation are almost as varied as the different health ministries sponsoring these opportunities. However, what seems to be a unifying thread throughout the different experiences is a desire on the part of both the physicians and the health ministry to establish a stable path to a community of support aligned with mission and spiritual growth. This concept of a community of support unfolds on both the professional and personal spheres and probably carries a different meaning for everyone who is involved.”

“What I am discovering is that physicians hunger to share experiences with other physicians. They sometimes struggle to keep a perspective that will promote their peace of mind, feed their original energy for service and also help them to grow professionally. Each physician has a different perspective and approach but the doctors find that in this non-threatening environment they enjoy hearing each other and finding a shared understanding. Most importantly, the discussions have tied their practice of medicine back to their own deeper values and beliefs. This feeds the ‘soul of their profession’ during these times of change when so much is shifting and evolving.”

How can mission leaders best partner with physicians in their practice of medicine?

“I have tried to be a background presence who is supportive and cares about them first as persons and secondly as physician. As I first worked with physician formation, my role was to listen, provide background explanation when needed and do the ‘leg work’ to bring the group together and be on the lookout for potential new members. The rest is up to the physicians themselves.”

“In the day to day operations of the hospital I provide the institutional reminder of the faith based roots of

Newly hired? Recently promoted?

Looking to brush up on some management skills?

RWHC offers a series of leadership development workshops that focus on the critical areas of success for health care leaders. Topics include skills like coaching, conflict resolution, clear communication, leading change—and many more. Check out the full leadership catalogue at www.RWHC.com. Workshops are offered to attendees at RWHC in Sauk City, and can also be custom designed to work with your leadership team in your community. This option has many advantages for your team as they learn together and it also saves you time and travel.

To learn more, contact Jo Anne Preston jpreston@RWHC.com or Carrie Ballweg cballweg@RWHC.com, or via telephone 608-643-2343 today!

healthcare. I offer the support to help keep this deeper meaning alive in the everyday working of the whole system. My encounters cover a wide range of interactions. They include things like providing an explanation of the Ethical and Religious Directives at a formal Ethical Consult, finding a way to provide a prescription to a patient without adequate insur-

ance and sitting in on interviews of new physician candidates. In each encounter I try to maintain that posture of supportive presence. This role flows into our formation sessions at which I mainly listen. Maintaining this posture of open listening and supportive presence, in the end builds the foundation on which other ways of interacting can be built.”

Transforming Practice One Nurse at a Time

National Nurses Week 2013 was May 6-12. To celebrate the diverse and important roles of nurses in health care, the Robert Wood Johnson Foundation and AARP sponsored Future of Nursing™ Campaign for Action asked Campaign partners to talk about their personal stories of transforming health care through nursing. The following is from “A Personal Journey: Transforming Practice One Nurse at a Time” by Cella Janisch-Hartline, RN, BSN, and Nurse Consultant at RWHC posted at <http://campaignforaction.org/>:

“I remember my first two weeks as a graduate nurse like it was yesterday: the pain, the tears, the disbelief, questioning everything without supportive colleagues and being thrown into situations with a sink or swim attitude by the experienced RNs. The phrase, ‘you are an RN, you should know that,’ still rings loudly in my ears to this day. Through the blood, sweat and tears I remember thinking, is this what I worked so hard for... is this what it’s like to be an RN? In those early moments of reflection and much soul searching, I de-

cided it was up to me to influence and change this profession one nurse at a time.”

“With great conviction and a ton of courage, I marched into my boss’s office and said ‘I know I don’t have much experience, but I want to help new nurses when they come on board. I want to be the person that makes their transition easier and more supported.’ To my amazement she said, ‘yes, let’s do it.’ That was only the beginning of a profound, intense, evolutionary journey which continues today. ‘Making a difference one nurse at a time’ has been my motto in the profession for years now.”

“Today, I am blessed to have a large forum to impact nurses as the coordinator/lead educator for the Wisconsin Nurse Residency Program at RWHC. Through Year 9, I have touched, influenced and supported 320 rural nurses within their first couple years of practice. Time and time again, I have witnessed their journeys unfold, like a flower blossoming one petal at a time, over the year that I get to spend with each of them. Throughout the program, each one of them is reminded regularly that each day, many times a day, they have to choose what kind of nurse they want to be. For me, not only do I get to impact them, they continue to transform me both personally and professionally. Their stories, their vulnerabilities, their willingness to allow me to be a part of their experiences, has been so spiritually moving. Now I understand why I had a rough start, because it was part of the preparation for my journey of impacting and transforming practice one nurse at a time.”

RWHC is co-lead with the Wisconsin Center for Nursing as the Wisconsin Action Coalition.

Leadership Insights: “May Day! May Day!”

The following is from RWHC’s *Leadership Insights* newsletter by Jo Anne Preston. Back issues are available at: www.RWHC.com/:

“Along with spring truly landing in Wisconsin, crying ‘May Day’ (asking for help) is not as easy as it

sounds for many managers. Common reasons we don’t delegate:

1. We feel like we are burdening others.
2. We are pretty sure we can do it better and quicker ourselves.
3. The last time work was delegated, it didn’t go so well.
4. We don’t want to give up work we like.
5. It takes longer to teach someone than to just do it ourselves.
6. Don’t have anyone to delegate to!”

“The downsides to managers of not delegating include stress, work/life balance out of whack, unable to meet our own workload, and feeling crabby that we are working so hard. But there is a downside to your employees as well: loss of the opportunity for growth. One perspective is that all the work *we* are currently doing was at one point delegated to us, and how would we have learned it if that had not happened?”

“There is a **sweet spot of internal motivation**, and it is when we have about a 50-80% chance of being successful. Lower odds leave us anxious; if work is too easy we get bored. Delegation needs to be tailored to each individual’s skill and experience that they bring to the task at hand, and **it is not an all or nothing proposition.**”

“Consider the trust you have with the employee, AND their level of skill and readiness before you decide how much to delegate. An example: you need to put together a report to determine if you should open a new service line for your area. *What level of delegation goes with what employee?*”

- **Level 1**—“With an employee who is new, inexperienced, or with whom you need to build confidence, ask them to go and **gather specific data only** (i.e., who else in the area offers the same service, how much they charge, their cost per case, waiting times to get into their service, staff requirements). No decision making is required on their part.”
- **Level 2**—“With an employee proven to be successful at completing a delegated task at Level 1, ask them to **share their thoughts about what they learned** in Level 1, their pros and cons of the new

service line. Still no decision making is required on their part.”



before to them and you never have to worry about whether or not it will get done well. You ask them to ***take on this project to its final completion***. Your bottom line accountability is their achievement of the final results.”

- **Level 3**—“A successful Level 2 earns your trust to ***make a recommendation to you*** based on their findings which you will take into consideration, perhaps asking them to draft an outline of the report based on why they believe the new service line is a good idea or not.”
- **Level 4**—“Recommendations from this employee in the past have been thoughtful, so you ask them to ***make a decision they can justify from their research***, and ***confer with you before beginning*** project implementation, in this case write a draft report but check with you before submitting a final report.”
- **Level 5**—“You have a history of sound decision making and accountability from this employee so you ask them to ***do the project and keep you informed along the way***. They will write the report keeping you posted at specified intervals.”
- **Level 6**—“This is the person you go to who you know you can fully count on. You have delegated

“CRITICAL to success at all levels: Clarity of your expectations (don’t make assumptions!), honest feedback and coaching along the way, and great listening. In delegating you are letting go of some of the tasks you might do well and even enjoy, but you are more fully embracing your role of developing others and managing the delegation process.”

(Levels of delegation adapted from Michael Hyatt’s Intentional Leadership.)

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

Space Intentionally Left Blank For Mailing