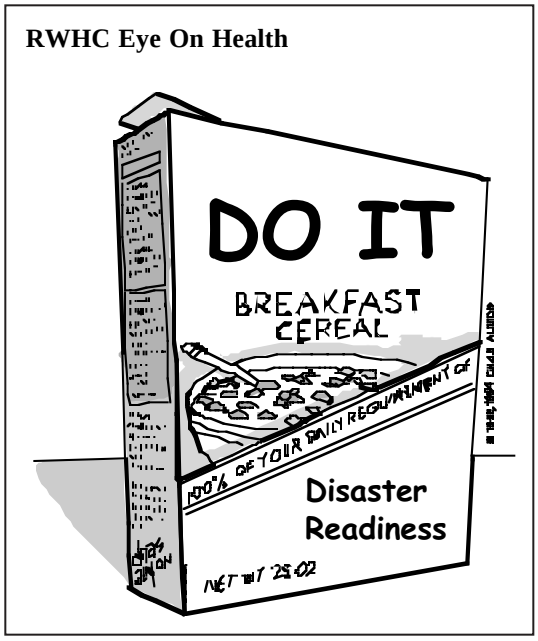
Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues from a Rural Perspective - January 1st, 2002

Terrorism Defense—Doing The Job At Home

The following is from "Hospital Resources for Disaster Readiness" by the American Hospital Association (AHA). They provide a credible roadmap toward ensuring the readiness of the nation's hospitals for all disasters, including terrorist attacks. "Operationally effective response systems must be defined and developed so as to be sustainable over time. All related training also must be sustained over time." AHA estimates the cost for the "average" metropolitan hospital at $3 million and for the "average" non-metropolitan hospital at $1.4 million—ten billion nationwide.



"AHA has developed an overview of the needs of the nation's hospitals related to future mass casualty events. Many experts agree that it is a matter of 'when' and not 'if' such an event will occur. The September 11th attacks, unfortunately, resulted in high mortality and few survivors. Hospitals were ready to respond but few patients appeared. The more recent spate of anthrax cases in Florida, New York, New Jersey and Washington, DC has been a further test of hospitals' readiness to address the increasing possibility of future mass casualty incidents."

"However, the stakes have clearly been raised since the September 11th attack. Hospitals need to upgrade their capabilities. In a nuclear, biological, or chemical (NBC) attack, hospitals would be severely challenged without access to additional resources. The recent anthrax scare has shown that hospitals can adequately respond to an attack yielding a small numbers of patients, but questions remain about their readiness to deal with larger scale attacks."

"Our resource estimates are based on a scenario that includes an event with casualties of 1,000 individuals seeking care at a metropolitan hospital and 200 individuals seeking care at a non-metropolitan hospital. We estimate what these hospitals would need in order to sustain these intense demands for approximately 24 to 48 hours. After this period of time, we assume that the Centers for Disease Control and Prevention (CDC) Bioterrorism Preparedness and Response program, especially its National Pharmaceutical Stockpile program, would be mobilized, and provide additional medical supplies to the impacted community."

"In this document, we have included only those items that would be essential for the short-term (24 to 48 hours) disaster response. However, we believe that what is ultimately needed, in both the short and long-term, is an operationally effective response system and the integration of hospitals into the community-wide response for mass casualty events. Because mass casualty events will, by definition, overwhelm the resources of a single hospital, they should be seen as community-wide concerns likely to require a broad array of community resources to supplement the health care system—**a community-wide perspective and community-wide planning is essential for readiness.**"

"Local government must be involved in planning, including the public health department, police and fire department. Other community resources are likely to be called upon and should be included in community-wide planning, including public transportation officials, news media, telephone and communication systems, schools, churches, voluntary disaster relief organizations, restaurants and food suppliers."

"The edge of the rut isn't the horizon." Original source unknown.

"**Communication and notification—**Mass casualty incidents create a demand for public information and multiple means for communication with community first responder organizations. In most cases, at least some of the information will not be readily available while the incident develops. In our mass media and multi-media culture, every news and information source will seek access to the latest and most up-to-date information. Absent clear and credible information, speculation may reign, and increase the stress and pressure of the incident, especially on the hospital and its staff. Therefore, planned and structured arrangements for communication throughout the incident and during its response are critical components of hospital and community preparedness. For example, all organizations involved in the community preparedness plan for mass casualties, including hospitals, need to agree in advance on who will serve as the single, regional spokesperson. To minimize disruption of patient care activities, press events should be conducted away from health care facilities, using regularly scheduled and pre-announced media briefing times."

"**Disease surveillance, disease reporting and laboratory identification—**A terrorist attack involving nuclear, biological or chemical agents could occur in an overt or covert manner. Most typical of terrorist actions to date is that of a sudden and highly localized event producing immediate casualties, such as an explosion. This is also the most likely scenario for an attack involving chemical weapons."

"Scenarios involving the deployment of a biological agent are expected to occur covertly, with increasing numbers of patients presenting to hospitals and physicians offices over the course of hours to weeks with signs and symptoms that may be common to many diseases and conditions. Radiologic agents could be released in either a covert or overt manner."

"**Improving hospital disease surveillance and disease reporting, and the public health infrastructure will be critical to determining that a cluster of disease may be related to the intentional release of a biological or chemical agent.** Particularly for biological agents, an effective medical response will be critically dependent upon the ability of individual clinicians, who may be widely scattered around a large area, to identify, accurately diagnose, and effectively treat an uncommon disease. To facilitate this level of readiness, laboratory diagnostic capability will need to be upgraded and laboratory personnel will require additional training."

"**Personal protective equipment—**Personal protective equipment (PPE) refers to clothing and respiratory apparatus designed to shield an individual from chemical, biological or other physical hazards. The 'universal precautions' (gloves, gown, mask, goggles, etc.) used by medical personnel to prevent infections will generally provide protection from the biological agents commonly considered to be threats. However, in the event of a large-scale biological event, hospitals would have to provide at least this level of protection to all staff. A hospital's daily inventory of such items would be quickly exhausted and the replacement of these supplies and equipment would be necessary. This is particularly the case because hospitals would have to be prepared to receive not only patients who would be decontaminated in the field, but also patients who 'walk in' without being decontaminated. Initial triage must be performed by health care workers in appropriate PPE. Today, hospitals generally are not stocked with suitable PPE to protect clinicians and other health care workers from exposure in the event of a biological or chemical attack, particularly one involving an unknown agent."

"**Dedicated decontamination facility—**Patient decontamination is the process of removing or neutralizing hazardous chemical, biological or radiologic agents from an injured or otherwise exposed individual in order to reduce the risk to the individual and minimize secondary exposure to health care workers and other patients in the facility. Hospitals should have a minimal level decontamination facility for ambulatory and non-ambulatory patients for small events; the ability to ramp-up quickly for a medium level event; and access to a regional decontamination facility for a large-scale event."

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural 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.

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"An outdoor facility or area can be effective, particularly to prevent contaminants from entering a fixed health care facility. An outdoor facility also is suitable for handling any large influx of injured or exposed individuals. It also holds the advantage of not requiring a dedicated air-handling and ventilation system, as would be required in an indoor decontamination facility. There are several drawbacks, including the requirement for providing protection from inclement weather and providing additional lighting. Each hospital must consider all such relevant factors in making a decision regarding appropriate decontamination facilities."

"**Pharmaceutical and other supplies—**Hospitals must be properly stocked with antibiotics, antitoxins, antidotes, ventilators, respirators and other supplies and equipment needed to treat patients in a mass casualty event. We assume that external sources of drugs and related supplies (e.g. CDC's National Pharmaceutical Stockpile) will be available within 24 hours of the detection of a biological or chemical agent. Therefore, hospitals would have to be prepared to sustain a 24-hour supply of pharmaceutical products at the most common dosage for the estimated number of patients and hospital personnel. Provisions and planning also must be made for appropriate dosages and formulations for children who may be victims. For medical/surgical supplies and equipment, a standardized formula must be developed to adequately determine stock requirements."

"For pharmaceutical and other supplies used rarely in the normal course of hospital activity, particular attention must be paid to appropriate dosing, shelf life and stock rotation issues. A plan for pooling of resources through mutual aid agreements among area health care facilities should be considered for such rarely used products and supplies."

"**Training and drills—**Staff training is needed at all levels of the organization for all types of potential disasters: nuclear, biological, chemical and conventional. The training needs to be stratified by educational level, from general staff awareness to technician level. Further, drills must be conducted at least twice a year, according to requirements of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and involve all key staff. Additional disaster drills beyond those required by JCAHO, particularly those integrated into local/state/federal disaster drills, would enhance the level of hospital readiness and staff competence in the event of a mass casualty incident."

"**Mental health—**Survivors of mass casualty events and responders to such incidents (fire, police, rescue workers, health care professionals, etc.) will suffer not only physical injury requiring medical care but also will undoubtedly undergo extreme psychological trauma. Thus the deployment of chemical, biological or nuclear agents against a population produces both acute and chronic psychiatric problems. In a disaster, several different groups would require mental health services, both direct and indirect."

"Beyond physical injuries, individuals who have survived a disaster also would be experiencing extreme emotional distress that could also manifest itself in physical conditions. This could include, but not be limited to, physical shock, hysteria, anxiety, fear, anger, frustration, and guilt, as well as an inability to communicate information critical to their treatment. For example, a survivor with a heart condition or asthma may require both immediate physical help and crisis intervention to be able to calm down and prevent further injury or distress. Finally, some individuals also may want to leave facilities to find loved ones or colleagues or to return to a safe place, whether or not they are physically or mentally able to do so. This might require close monitoring or short-term containment."

Mark Your Calendar: April 4th, Madison Wisconsin Farm Health Summit

Hosted by Wisconsin Secretaries of Commerce, Health and Agriculture

For information contact:
jmthomas@commerce.state.wi.us

The complete AHA set of guidelines is available for both members and non-members at:

www.aha.org/Emergency/EmIndex.asp

Red Cross & Hospitals Parting Company?

From "Area Hospitals Feeling Impact Of Red Cross Price Increase" by Ben Bromley, Central Wisconsin Newspapers News Service, 12/17/01:

"Price increases for American Red Cross blood has area hospitals and a state lawmaker demanding answers. The Red Cross significantly increased its prices for red blood cells in July. Since prices vary on shipping costs and purchase quantity, they've affected hospitals differently. In central Wisconsin, prices increased 70 to 100 percent."

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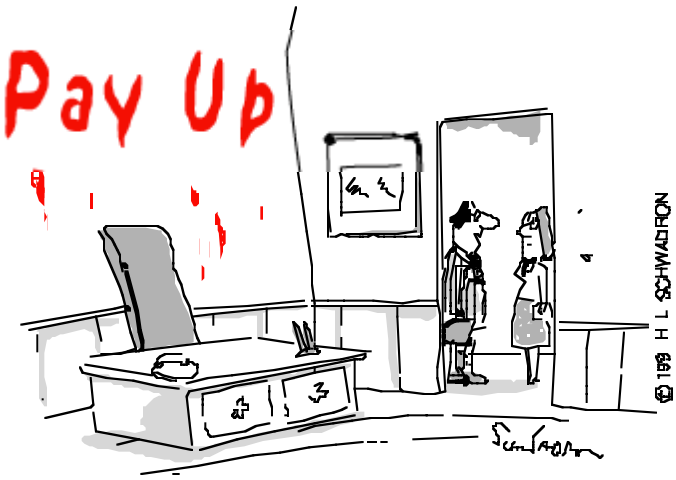

"Any messages while I was out?"

"State Sen. Dale Schultz questioned the price increases recently, saying they unfairly impact small, rural hospitals. He has already sought an explanation from the regional director of the Red Cross blood program, and plans to conduct hearings on the issue in the Legislature. He may even ask Wisconsin's congressional delegation to get involved."

"Schultz, a Richland Center Republican, said he's investigating blood prices because he wants to ensure hospitals in his rural six-county district aren't being gouged. Schultz said he can't understand why a nonprofit would need to increase prices as much as 100 percent. 'At this point, somebody has to do the spade work—to dig up information."

"The Red Cross price increase has members of the Rural Wisconsin Health Cooperative, a Sauk City-based organization of 28 area hospitals, steaming. 'We feel they thought they could really just take advantage of rural hospitals,' said director Tim Size."

"He said many hospitals in the cooperative seek new blood suppliers. Doing so has proved challenging because the Red Cross built a blood service that's practically a monopoly, leaving hospitals with few alternatives when price hikes were announced. 'I can't just go down to the mall and grab some blood,' Size said."

"**Rising costs**—Two key factors drove price increases, said Red Cross spokeswoman Blythe Kubina: Processing costs and poor budgeting. Kubina said costs of testing, separating and processing donated blood have risen 27 percent in the past five years. She said building testing laboratories, implementing new testing procedures and creating a national computer system have improved the availability and safety of blood, but those investments have come at a price."

"The Red Cross had to increase costs this year to balance its budget. While costs were increasing 27 percent over the past five years, prices increased only 10 percent. Now the national nonprofit is playing catch-up. 'Our goal was to better align our costs and our prices,' Kubina said."

"**Price disparities**—Schultz said he's concerned not only with the steep nature of July's price increase for red blood cells, but the variance in rates Red Cross charges. The Red Cross imposes additional fees when hospitals return still-usable blood or fail to buy a minimum number of units . Plus, since the rates are based in part on shipping costs, rural hospitals pay higher rates because they tend to be located farther from distribution centers. Because of those factors, the legislator said costs are being shifted unfairly to rural hospitals in south central Wisconsin."

"Size said members of the Rural Wisconsin Health Co-op—hospitals in Baraboo, Mauston, Portage, Prairie du Sac and Reedsburg belong to the association—are getting short-changed. The Red Cross benefits from area residents' willingness to donate blood, yet refuses to give local hospitals a break by allowing them to buy blood in bulk as a group. "They're not willing to help subsidize the unique costs of serving these communities," he said."

"Such sentiments are common among area hospital officials. Dan Manders, president of Mile Bluff Medical Center in Mauston, said the July hike increased his hospital's blood costs 100 percent. Manders said he and his colleagues feel that 'the Red Cross is not concerned about the hospitals in rural areas.' "

"At Reedsburg Area Medical Center, the cost increased from $126 to $214 per unit, a jump of 70 percent, said Jean Klang, director of laboratory services."

"**Potential changes**—The price increase prompted Mile Bluff officials to consider switching blood suppliers. South central Wisconsin hospitals may follow the lead of University of Wisconsin Hospital in Madison, which recently signed a $4.5 million-a-year contract with LifeSource Blood Services in suburban Chicago. That move is expected to save UW Hospital about $2 million a year over what the Red Cross would have charged."

"Such changes must be made, Manders said, because hospitals can't immediately pass this added cost along to consumers. Insurers and government programs such as Medicare only pay so much for care, and hos-

pitals will end up eating this unexpected expense in the short term."

"Unless hospitals can find cheaper blood supplies, they'll have to trim budgets elsewhere or increase prices later. 'I think we're all concerned about our costs,' Manders said. "We hate to see things drive that cost up higher.' "

"Size noted that increased costs for all patients will be borne primarily by those not covered by Medicare or Medicaid. 'That starts to get real serious,' he said. 'It's a big hit.' "

"Despite all the concerns about the price increase, Schultz said he still encourages donors to give blood. He also praised Jo Musser, director of Badger-Hawkeye Region Blood Services, for agreeing to address the issue with the Red Cross national office and discuss it with the Rural Wisconsin Health Cooperative. 'I hope people, especially at this time of year, continue to give blood,' Schultz said."

Medicare Board Needs Rural Voices

From "Health Group Takes Aggressive Stance On MedPAC Rural Nominations" in *Inside CMS*, 12/7/01:

"Pushing for increased rural representation on Congress, major Medicare advisory body, a leading rural health group today broke with tradition and nominated a handful of candidates to the Medicare Payment Advisory Commission (MedPAC)."

"Adopting a much more aggressive approach, the National Rural Health Association (NRHA) has nominated five candidates for the upcoming MedPAC vacancies next year because of the 'woeful and inadequate rural representation on MedPAC,' a NRHA source says."

"Currently, two of MedPAC,s 17 commissioners are perceived as being rural representatives, sources say. NRHA urged HHS Secretary Tommy Thompson in October to support increases in the number of rural MedPAC commissioners proportionate to the rural Population."

"Commenting on the Dec. 6 nominations, NRHA President Charlotte Hardt said that a two-tiered system of health care for the nation,s rural elderly is rapidly developing. 'This is something health care professionals living in rural America know, and it is important that policy experts in Washington recognize what is happening in rural America.' "

"Lamenting the need for adequate rural MedPAC representation, NRHA points to a recent Center for Disease Control and Prevention report which found that Americans living in rural areas fare significantly worse in many key health measures than those living in the suburbs and large metropolitan areas."

" 'With one in four Medicare beneficiaries living in rural communities, this underserved population is also being underserved by the very committee that was designed to assist in achieving better health care options for Americans in need of medical services,' Hardt says. 'The five NRHA nominees are: Former Federal Office of Rural Health Director Wayne Myers; the Department of Preventive and Societal Medicine's Health Services Research and Rural Health Policy head Keith Mueller; Rural Wisconsin Health Cooperative Executive Director Tim Size; Trinity Health Systems President Thomas Tibbitts; and current MedPAC incumbent Mary Wakefield."

"Aside from advising Congress on payments to health plans participating in the Medicare+Choice program and providers in Medicare,s traditional fee-for-service pro-gram, MedPAC is also tasked with analyzing access to care, qualify of care, and other Medicare issues. In related news, sources indicate that Senate Finance Chairman Max Baucus (D-MT) will also likely support rural nominations for the next year."

CAH & BIPA Counter BBA

From "Rural Hospitals' Ability to Finance Inpatient, Skilled Nursing and Home Health Care" by Jeffrey Stensland and Ira Moscovice, University of Minnesota Rural Health Research Center Working Paper Series, 10/01:

"The Balanced Budget Act of 1997 dealt a severe financial blow to most rural hospitals by reducing

Medicare payments for inpatient, outpatient, skilled nursing care, and home health care. We selected a random sample of 448 rural hospitals to investigate how rural hospitals are restructuring their operations in response to the BBA. The objective is to determine if rural hospitals have closed, raised prices, or ceased offering certain services as strategic responses to the BBA. This is the first survey to focus specifically on rural hospitals' strategic responses to the BBA."

"The most popular strategy for small rural hospitals is to convert to Critical Access Hospital status. Small hospitals that agree to a limit of 15 acute care patients can usually be declared a Critical Access Hospital and obtain cost-based reimbursement for inpatient and outpatient care. Nineteen percent of the hospitals surveyed converted or are in the process of converting to Critical Access Status, and another 16% are considering a conversion. For the 35% of rural hospitals that have converted or are considering a conversion to Critical Access Hospital status, the BBA may have a positive impact on their financial stability. Large and mid-sized hospitals do not have the option of conversion and were forced to absorb BBA payment cuts."

"The reductions in Medicare payments of SNF and home health care have forced the closure of some rural hospitals' post-acute care services. Thirteen percent of rural hospitals that operated a home health agency in 1997 closed their home health agency by October 2000. Fourteen percent of hospitals that operated a skilled nursing facility in October 1997 closed their facility by October 2000."

"Fortunately for rural patients, the financial strains experienced by rural hospitals have not caused a major reduction in patients' access to care. Among the 448 rural hospitals that were randomly selected from the population of hospitals that were operating in 1997, none were permanently closed between October 1997 and October 2000. Given this finding and comments by survey respondents, it appears that the Critical Ac-

Health Care Expenditures--How Is Wisconsin Doing?

All Rankings Are From Highest To Lowest.

Indicator	Rank	WI	U.S.	WI % U.S.
Family Health Insurance Premium [1]	6th	$6,475	$6,058	107%
Average Price of Retail Prescription [2]	10th	$47.53	$45.43	105%
Personal Health Care Expenditures Per Capita [3]	17th	$3,892	$3,750	104%
Hospital Adjusted Expenses per Inpatient Day [4]	28th	$1,064	$1,103	96%
Employee Share Family Health Insurance Premium [5]	30th	$1,385	$1,438	96%
State Government Health Care Expenditures per Capita [6]	32th	$767	$872	88%
Medicare Payments Per Enrollee [7]	35th	$4,500	$5,490	82%
Hospital Admissions per 1,000 Population [8]	36th	103	118	87%
Federal Dollars Returned To State [9]	44th	83%	100%	83%
Uninsured Rate [10]	48th	10%	16%	63%

Notes:

1. Average Annual Cost of Employment-Based Health Insurance--Family Coverage, 1999, Total
2. Average Price of Retail Prescriptions in Dollars, 2000
3. Per Capita Personal Health Care Expenditures, 1998
4. Hospital Adjusted Expenses per Inpatient Day, 1999
5. Average Annual Cost of Employment-Based Health Insurance--Family Coverage, 1999, Employee Share
6. State Health Care Expenditures per Capita, SFY1999
7. Medicare Estimated Benefit Payments By State Per Enrollee For Fiscal Year 2000
8. Hospital Admissions per 1,000 Population, 1999
9. Federal Expenditures in the State Per Dollar of Federal Taxes, FFY2000
10. Population Uninsured, 1997-1999

Data: Kaiser Family Foundation's State Health Facts Online: www.statehealthfacts.kff.org

Chart: RWHC 12/11/01

cess Hospital provision of the BBA is preventing hospital closures."

"It also appears that the vast majority of rural patients still have access to one or more skilled nursing facilities and one or more home health agencies. In all but one of the cases where a hospital closed their skilled nursing facility, another skilled nursing facility was operating within 15 miles of the hospital. In all but one of the cases where a home health agency closed, another home health agency served the community."

"Looking forward, we see some improvements in rural hospital profitability. In December of 2000, the Benefits Improvement Act of 2000 (BIPA) was passed. The BIPA will improve payments for skilled nursing care and home health care in rural areas. The BIPA will also allow Critical Access Hospitals to receive cost-based reimbursement for the post-acute care they provide Medicare patients in swing beds. Due to the BIPA and rural hospitals' past cost-cutting efforts, we do not expect to see a further reduction in hospital-owned home health agencies or skilled nursing facilities."

The Hidden Driver of Great Performance

From "Primal Leadership: The Hidden Driver of Great Performance"–a *Harvard Business Review OnPoint Article,* 12/01. The complete article can be ordered online at: www.hbsp.harvard.edu.

"What most influences your company's bottom-line performance? The answer will surprise you—and make perfect sense: **It's a leader's own mood."**

"Executives' emotional intelligence—their self-awareness, empathy, rapport with others—has clear links to their own performance. But new research shows that a leader's emotional style also drives everyone else's moods and behaviors—through a neurological process called *mood contagion*. It's akin to 'Smile and the whole world smiles with you.' "

"Emotional intelligence travels through an organization like electricity over telephone wires. Depressed, ruthless bosses create toxic organizations filled with negative underachievers. But if you're an upbeat, inspirational leader, you cultivate positive employees who embrace and surmount even the toughest challenges."

10th Annual $1,000 Prize For the University of Wisconsin's Best Rural Health Paper

Write on a rural health topic for a regular class and submit a copy as an entry by April 15th The Essay Prize, established in 1993, is open to all students of the University of Wisconsin. The writer of the winning essay will receive a check for $1,000 paid from a trust fund established at the University by RWHC, family and friends of Hermes. All entries must be submitted by April 15th c/o Monica Seiler, RWHC, P.O. Box 490, Sauk City, Wisconsin, 53583 with writer's name, academic program and expected date of graduation. Additional information is at:

www.rwhc.com/essay.prize.html

The Review Committee, comprised of RWHC and UW representatives, reserves the right to not award the Prize.

"Emotional leadership isn't just putting on a game face every day. It means understanding your impact on others—then adjusting your style accordingly. A difficult process of self-discovery—but essential before you can tackle your leadership responsibilities."

"Since few people have the guts to tell you the truth about your emotional impact, you must discover it on your own. The following process can help. It's based on brain science, as well as years of field research with executives. Use these steps to rewire your brain for greater emotional intelligence."

1. "**Who do you want to be?** Imagine yourself as a highly effective leader. What do you see? *Example*: Sofia, a senior manager, often micromanaged others to ensure work was done 'right.' So she imagined herself in the future as an effective leader of her own company, enjoying trusting relationships with coworkers. She saw herself as relaxed, happy, and empowering. The exercise revealed gaps in her current emotional style.

2. "**Who are you now?** To see your leadership style as others do, gather 360-degree feedback, especially from peers and subordinates. Identify your weaknesses and strengths."

3. "**How do you get from here to there?** Devise a plan for closing the gap between who you are and who you want to be. *Example*: Juan, a marketing executive, was intimidating, impossible to please—a

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Leaders depend on others to buy their mirror.

grouch. Charged with growing his company, he needed to be encouraging, optimistic—a coach with a vision. Setting volunteered at a crisis center, and got to know subordinates by meeting outside of work. These new situations stimulated him to break old habits and try new responses."

4. "**How do you make change stick?** Repeatedly rehearse new behaviors—physically and mentally—until they're automatic. *Example***:** Tom, an executive, wanted to learn how to coach rather than castigate struggling employees. Using his commuting time to visualize a difficult meeting with one employee, he envisioned asking questions and listening, and mentally rehearsed how he'd handle feeling impatient. This exercise prepared him to adopt new behaviors at the actual meeting."

5. "**Who can help you?** Don't try to build your emotional skills alone—identify others who can help you navigate this difficult process. Managers at Unilever formed learning groups that helped them strengthen their leadership abilities by exchanging frank feedback and developing mutual trust."

The 5th Annual Workshop by the Wisconsin Health & Educational Facilities Authority—"Insights Into Capital Finance" is March 18th at the Country Inn Hotel in Waukesha. This workshop is designed for financial executives of all Wisconsin tax-exempt healthcare and higher educational institutions—"to address the needs of the first time borrower and the seasoned alike." For more information, email: whefa@execpc.com

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