

**U.S. Senate Special Committee on Aging
A Hearing on “Growing Old in Rural America” July 31st, 2008**

Testimony: “Assuring Healthcare ‘Reform’ Doesn’t Bypass Rural America”

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I. Introduction: Much of the Healthcare “Reform” Debate Misses Critical Rural Issues

Rural health is at risk with healthcare reform. It is at risk without it. Rural does not drive this train, but we have a voice that must be heard.

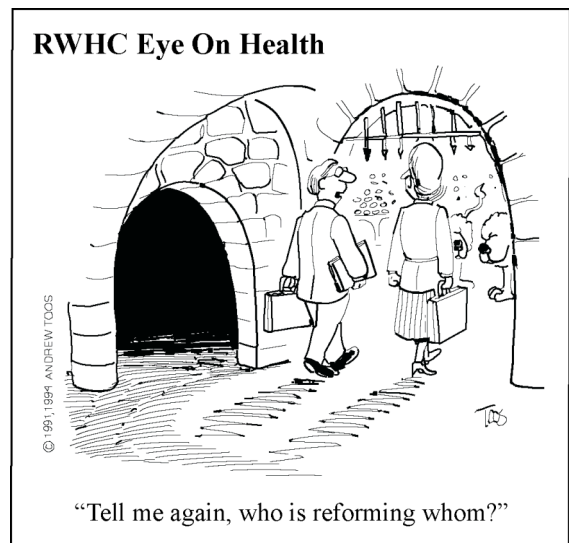
Healthcare in America is neither equitable nor can it continue to work as we have known it. We must continue to make it better. Whether the reform is in small pieces over time or all at once like the birth of Medicare, every approach includes tradeoffs. Different ways, including doing nothing, will affect key interests and goals differently. These goals help and compete with each other, whether they address cost, the uninsured, quality, fairness, benefits, choice or making communities healthy.

Those of us who care about rural health have the same diversity of opinion about healthcare reform as the whole country does. But we must find common ground on those issues that hit hard our rural communities, whether or not they are on anyone’s reform agenda. I would like to address three such issues today that must have significantly greater attention in Washington DC and in each of our states:

- ✓ Make the Health Workforce a Priority
- ✓ Hold Medicare Advantage Plans Accountable
- ✓ Invest in Healthy Communities

For each of these three issues, this testimony will discuss the issue from a national perspective and then, as an example, note how it is currently playing out in Wisconsin.

Both nationally and in Wisconsin, rural health’s many successes are a testament to the endurance and creativity of rural communities. Reform needs to build on that strength, not weaken it.



II. Make Health Workforce a Priority

The National Perspective—The Association of Academic Health Centers issued on July 17th “*Out of Order, Out of Time: The State of the Nation’s Health Workforce*” which “focuses attention on the critical need for a new, collaborative, coordinated, national health workforce planning initiative. The report’s seven chapters include more than 40 findings that document what is ‘out of order’ with respect to the nation’s health workforce, as well as the looming social and economic forces that leave no time for further delay before the problems get dramatically worse.”

The report draws several broad conclusions from the detailed findings including:

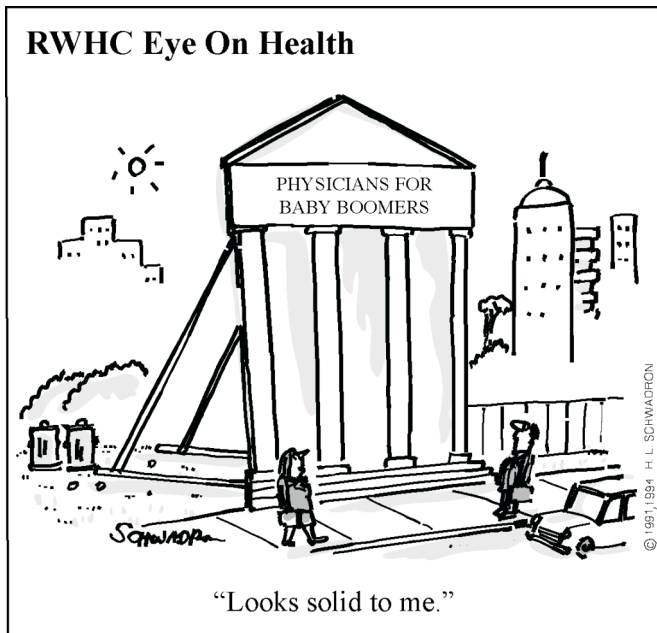
- “A broader, more integrated national strategic vision than our historic approach to health workforce policymaking and planning is needed if complex and urgent health workforce issues are to be addressed effectively.
- A new mechanism is needed to serve the currently unfilled integrative role that existing health workforce policymaking and planning processes are not designed, and are ill-equipped, to serve.
- It is critically important to act immediately to develop and implement an integrated, comprehensive national health workforce policy before intensifying health workforce needs outpace available resources, putting the U.S. at risk of losing its status as the global health care leader.”

The report recommends that all public and private stakeholders work together to:

- “Make the U.S. health workforce a priority domestic policy issue;
- Begin addressing national health workforce issues immediately to avert crises in national workforce capacity and infrastructure;
- Develop an integrated, comprehensive national health workforce policy that recognizes and compensates for the inherent weaknesses and vulnerabilities of current decentralized multi-stakeholder decision-making; and
- Create a national health workforce planning body that engages diverse federal, state, public and private stakeholders with a mission to:
 - Articulate a national workforce agenda;
 - Promote harmonization in public and private standards, requirements and prevailing practices across jurisdictions;
 - Address access to the health professions and the ability of educational institutions to respond to economic, social, and environmental factors that impact the workforce; and
 - Identify and address unintended adverse interactions among public and private policies, standards, and requirements.”

A similar call to action entitled “For the Healthcare Work Force, a Critical Prognosis” by Daniel W. Rahn and Steven A. Wartman was published in *The Chronicle of Higher Education* on November 1st, 2007:

“The United States faces a looming shortage of many types of healthcare professionals, including nurses, physicians, dentists, pharmacists, and allied-health and public-health workers. The results will be felt acutely within the next 10 years.”



“The final crucial factor precipitating the healthcare-work-force crisis is a lack of comprehensive work-force planning on the parts of academe, government, and the healthcare professions. We need strategic direction instead of the current piecemeal approach at the national and state levels; both federal and state policy making has tended to respond to immediate crises or issues related to one particular profession or constituency. Commissions and task forces abound, yet many reports gather dust on shelves; the infrastructure for putting good ideas or new policies into effect is at best uneven.”

“The healthcare shortage we face is serious. Some experts may argue that there is no cause for alarm, because work-force shortages are cyclical, market-driven, and easily ameliorated. But that perspective is not valid today. The work-force shortfall in healthcare cannot be resolved in the marketplace alone. It is time for organized action, not only within colleges, but also at our nation’s highest levels.”

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At the Same Time, Rural Faces Uncertainty about Health Professional Service Area (HPSA) Eligibility

On another front, the Department of Health & Human Service’s (DHSS) proposal to “reform” the designation of health professional shortage areas will further penalize states with insufficient workforce data. [DHHS has just announced plans to revise their originally proposed new Rule and will re-issue as a new Notice of Proposed Rule-Making with a new Comment period.] According to the State of Wisconsin’s May 27th comment on the earlier proposed new rule for Health Professional Shortage Area designations, the economic burden on states for data reporting for HPSA designations is not reduced but substantially increased:

- “Although the Health Resources & Services Administration (HRSA) will be able to make some of the federally-collected population and high-need indicator data available to states, the national provider datasets are not current or detailed enough for HPSA designations.”
- “When Wisconsin conducted testing of the new HPSA Rule using the national physician data and mid-level state professional association data, the vast majority of current HPSAs do not qualify for a new Tier-1 geographic HPSA and consequently could lose access to critical federal resources.”
- “The majority of states (83%) currently do not have the detailed mid-level data needed for this new HPSA Rule (24 out of 29 states in a recent survey of state primary care offices). And all responding states indicate they already have to do additional data collection and/or cleaning to get the detailed physician data needed for HPSAs (31 out of 31 states).”

- “State primary care offices have not received any significant increase in their federal grants in more than 15 years to support their HPSA data collection and analysis. It is very labor intensive to collect the detailed provider Full Time Equivalent (FTE) and patient population data that are needed for HPSA designations.”
- “Even the HRSA Shortage Designation Branch acknowledged that the AMA physician data and national mid-level provider data used for federal testing of the new HPSA Rule are not very accurate or up to date.”

Examples from Wisconsin—It is important to note that Wisconsin’s Department of Workforce Development has given needed visibility to the overall problem of health workforce shortages; it has generated reports based on currently available data and helped identify and is promoting needed best practices such as the voluntary “no-lifting” program. I would also like to acknowledge examples of important work such as the Wisconsin Hospital Association’s “Who Will Care For Our Patients” (on the growing shortage and maldistribution of physicians) and various regional retirement and departure surveys directed at health sector employers and employees.

How are we failing?

Even with such efforts, Wisconsin’s very own “inconvenient truth” is that we do not have a system to produce ongoing, labor market specific information that would allow us to make knowledgeable projections about healthcare workforce shortages. In turn, such a system would allow us to better target the needed investments in our post secondary educational and vocational systems.

Due to limited resources and instances where collaboration needs to be substantially enhanced, our current approach to healthcare workforce planning falls far short because as regards to job vacancies, we don’t know where we are or where we are going.

Regarding the strategic investments and changes that need to be made in and by Wisconsin’s universities, colleges and schools, we are playing a high stakes game of “blind man’s bluff.” Do we have the right number of nursing schools? Are we producing the right number of ADN and BSN graduates? Are we graduating enough physicians in the needed disciplines who are prepared to work in all of Wisconsin, not just selected communities? Isn’t a second school of dentistry long over due, explicitly designed to address our states chronic shortage of dentists accessible to the uninsured? Can we change the share of our pharmacy graduates going into rural practice from 6 percent to something closer to a replacement rate of 30 percent?

The problem is that we have a fair amount of data but not much information upon which to make knowledgeable workforce development decisions in or for either public or private sectors. We tend to know how many people are employed in various occupations but not whether they work full time or part-time or for multiple employers nor how many vacancies currently exist or are projected to exist.

What can we do?

The Federal Health Resources and Services Administration has a Workforce Shortage Forecasting tool but its estimates for future shortages in Wisconsin are based on relatively small sample sizes and to date have been mostly limited to Nursing. We need to better understand the HRSA model, the “simplifying” assumptions it makes and the data inputs it needs to produce usable outputs.

Regardless of what predictive model we end up using, its outputs will only be as good as the inputs; and good inputs require more collaboration than we have yet seen. Critically important data we need but currently do not have access to includes, but is not limited to (a) number of first time licenses by year, (b) number of license renewals (c) age of each license holder, and (d) for new licenses: the degree granting school and year the degree was awarded. In Wisconsin, we need to either mandate survey participation as part of the health professions licensure process or make it hard to avoid.

The professional licensing process in North Carolina and Minnesota is an integral part of the state's workforce planning process; we can and must do as well in Wisconsin.

We must also find a way for employers and academic institutions to join government in this work. Various claims of "it's not my responsibility" or we have a "proprietary interest in 'our' data" is crippling our ability to appropriately plan for our collective future workforce needs. We must develop mechanisms that aggregate survey data from regional and other efforts.

Once we have the data to mathematically project estimates of shortages and perhaps in some instances, surpluses, we need to have an organized infrastructure to turn the data into information and knowledgeable estimates that can inform our investments in education, training and other interventions. While we need to start with mathematical projections, by themselves they are not useful. We need to add what we know may or could be happening to impact relevant policy that wasn't otherwise incorporated into the model's assumptions. We must look beyond statewide numbers to regional data analysis so we can understand and address how shortages vary around the state, with a particular focus on traditionally underserved communities, rural and central city.

We need to get real about resources. It would be helpful to know what the best practices are in other states regarding projecting specific healthcare workforce shortages; and what resources they allocate for the process. We are already behind in addressing in preparing for the future as Wisconsin (a) is a "graying state," with a larger proportion of its residents in or close to an age that typically brings a much higher need for medical care, (b) we already are facing significant shortage and misdistributions and (c) the lead time to make strategic changes in our healthcare education and training infrastructure is limited.

Wisconsin needs more caregivers at the same time workforce participation is declining. It was fun to play blind man's bluff as a kid but not now, given the high stakes of baby boomers retiring out of providing care and entering a stage of life where they will increasingly need it.

Due to limited resources and instances where collaboration needs to be substantially improved, our current approach to healthcare workforce planning falls far short because as regards to job vacancies, we don't know where we are or where we are going. Our future patients requires us to do better.

III. Hold Medicare Advantage Plans Accountable

The National Perspective—The following is from the National Rural Health Association's April, 2007 Policy Brief entitled, "Medicare Advantage for Rural America?"

"The enactment of the Medicare Prescription Drug Improvement and Modernization Act of 2003 fundamentally changes Medicare in ways not yet understood by either the public or providers. Medicare Advantage (MA) is intended to fulfill the goals of (1) substantially increasing the number of Medicare beneficiaries enrolled in private health insurance, based on the premise believed by many policy mak-

ers that competition among these private health plans and between these plans and the traditional fee-for-service Medicare program will reduce federal spending; and (2) creating opportunities for beneficiaries to enroll in richer benefit packages than available through traditional Medicare (sometimes with tradeoffs regarding choice of providers and drug formularies, and often-times at a higher cost than the cost of care under traditional Medicare fee-for-service). Policy makers may also believe, at least implicitly, that private health plans can be held accountable for healthy outcomes for enrollees, as measured against benchmarks established by the National Committee for Quality Assurance.”

“The focus of this Policy Brief is to address MA implementation issues relevant to rural communities. It assumes that the federal policy of ‘privatizing’ Medicare to create a competitive structure to cut costs will continue. It is left to others to argue the probability of MA taking permanent root in rural America, in a way its predecessor, Medicare+Choice, did not. What we do know is that if MA plans gain rural market share, the potential consequences to rural health is significant, and potentially quite negative.”

“Rural America cannot wait to see what MA does or doesn’t do. Potential problems need to be identified and resolved before the MA program becomes entrenched and less readily adjusted. MA must be implemented in a manner that is sensitive to the needs of rural communities. If not, the negative impact on the rural healthcare infrastructure could take a generation to rebuild. Medicare beneficiaries should not be required to lose access to local services to obtain the promise of increased benefits. NRHA made the following recommendations:

1. “The Congress should pass legislation that ensures Critical Access Hospitals and Rural Health Clinics are paid by MA organizations an amount equivalent to or no less than they would be paid by traditional Medicare.”
2. “The Centers for Medicare & Medicaid Services (CMS) must engage with rural health experts regarding how best to determine and enforce rural community access standards consistent with individual communities’ historic/present patterns of care. CMS must also engage with rural citizens about these standards by developing more user- friendly web sites, train more call center workers who understand the ‘older learner’ and/or their (mature) children or friends who have questions.”
3. “CMS must take action to ensure that beneficiaries are given the information and support to allow them to make well-informed decisions, particularly for rural beneficiaries who typically have less experience with managed care.”
4. “CMS Regional Offices must regain their role as an access point by providers in their regions for definitive MA information and an ombudsman for dispute resolution with plans.”
5. “CMS needs to continue providing county or equivalent specific plan enrollment data and in a timely manner (quarterly over time).”



6. "A web site is needed for providers to verify beneficiaries' current plan enrollments."
7. "The approval process of MA plans and amendments needs to be transparent, including web-based access to the details of the approved applications."
8. "Payments to MA plans should not rely on a payment mechanism that rewards regions with high utilization at the expense of regions with lower utilization."
9. "Administration of PFFS plan payments to non-contracted providers needs to be improved. Situations where intermediaries artificially keep interim rates low as well as not including the Certified Registered Nurse Anesthetist pass-through and bad debt in interim rates, need to be addressed."
10. "The Federal Office of Rural Health Policy should be given expanded authority to provide technical assistance and outreach on ways rural providers can collaborate in the review of MA contracts."
11. "Congress should increase funding for local organizations serving the elderly to provide increased technical assistance to beneficiaries enrolling in MA plans."
12. "State insurance commissioners' offices should be encouraged to act as state level ombudsmen for rural beneficiaries enrolled with MA plans."

"Medicare Advantage is still unfolding, with its full effect yet to be seen. If the privatization of Medicare in rural America is only partially accomplished, the rural health landscape will be significantly transformed. It is imperative that (1) rural beneficiaries are ensured appropriate access to local care, (2) rural beneficiaries have access to and receive the benefits equivalent to those able to be offered by MA in urban communities, (3) payment rates are high enough to sustain a viable rural health system, and that (4) the relationship among beneficiaries, providers, plans and, CMS be well integrated."

Examples from Wisconsin—According to figures released by CMS for March of this year, almost 200,000 of Wisconsin's 850,000 Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans. The comparable enrollment for 2007 was 150,000. This represents an increase of over 30% from 2007 with nearly 1 in 4 of Wisconsin beneficiaries now enrolled in Medicare Advantage. While slightly higher than the national average, what is most noteworthy in Wisconsin is that Medicare Advantage market penetration is on average as high in rural counties as urban.

With the exception of the Regional PPO Plan, plans are approved and marketed by county. This means that within a given county, market penetration may vary significantly from what the statewide average indicates. As indicated below, county level market shares in Wisconsin range from 8% to 56%.

Since the Private Fee for Service (PFFS) plans comprise such a large segment of enrollment in replacement plans by Medicare beneficiaries in Wisconsin, it is important to understand how

Wisconsin Medicare Advantage Plan Enrollment

WI Plans by Type	Enrollment
Private Fee for Service (PFFS)	118,234
Local HMO/POS Plans	52,992
Local PPO Plans	12,902
1876 Cost Plans	11,540
Regional PPO Plans	997
National PACE Plans	728
Total	197,393

Source: Centers Medicare & Medicaid Service for enrollment as of March, 2008

these plans operate. A Medicare PFFS plan is a Medicare Advantage health plan offered by a private insurance company under contract to the Medicare program. Medicare pays a set amount of money every month to the PFFS organization to arrange for healthcare coverage for Medicare beneficiaries who have enrolled in the Medicare PFFS plan.

Enrollees in a Medicare PFFS plan can obtain plan covered healthcare services from any eligible provider in the U.S. who is willing to furnish services to a PFFS enrollee. Given the recent passage of Medicare Improvements for Patients and Providers Act (MIPPA), how this legislation will be applied is not yet fully understood but the following is still expected to be a fair general description of how PFFS are working in rural markets.

Medicare PFFS plans are not required to contract with any Providers. Providers become aware that beneficiary participates in a Medicare PFFS plan when the beneficiary presents their enrollment card. A provider is a deemed provider and must follow a PFFS plan's terms and conditions of participation if the following conditions are met: a) in advance of furnishing services the provider knows that a patient is enrolled in a PFFS plan and b) the provider either possesses or has access to the plan's terms and conditions of participation.

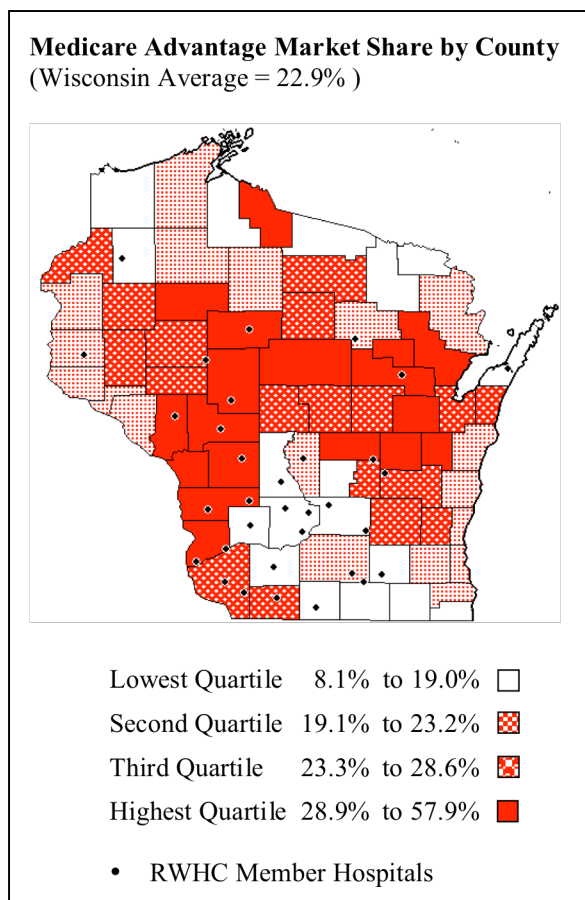
It is important to note that a provider is not required to furnish healthcare services to enrollees of a Medicare PFFS plan. However, when a provider chooses to furnish services to a PFFS enrollee and the deeming conditions have been met, the provider is automatically a deemed provider (for that enrollee) and must follow the PFFS plan's terms and conditions of participation.

The terms and conditions of participation establish the rules that providers must follow if they choose to furnish services to an enrollee of a PFFS plan.

A PFFS organization is required to make its terms and conditions of participation reasonably available to providers from whom its enrollees seek healthcare services. This generally means that the organization offering the PFFS plan will post its terms and conditions on a web site and make them available upon written or phoned request.

Given the ease with which hospitals will be "deemed" to be contracting providers, it is important that hospitals understand the basics concerning how Medicare PFFS plans operate and take steps to identify the specific Medicare PFFS plans that will be operating in their area (and their specific terms and conditions of participation).

Providers can decide to contract with a particular Medicare PFFS plan, either directly or by deeming, and make such decision known to admissions staff. Hospitals are not obligated to serve Medicare beneficiaries enrolled in PFFS plans, except in emergency situations governed by EMTALA. It may be a



difficult decision for providers to deny services to a Medicare beneficiary who participates in a Medicare PFFS plan.

A Medicare PFFS plan must establish uniform payment rates for all contracted providers (those with written contracts and those deemed to be contracted providers). The Medicare PFFS plan must pay both contracted and “deemed” contracted providers the fee-for-service amount specified by the plan in the terms and conditions of payment for the particular service minus any applicable enrollee cost-sharing.

If a Medicare PFFS plan has an insufficient number of contracted hospital providers to furnish the services covered under the Medicare PFFS plan, it must pay all hospital providers (contracting, deemed and non-contracting) at least what they would have been paid under original Medicare and may not vary beneficiary cost sharing.

In Wisconsin, we see Medicare beneficiaries not knowing they are MA enrollees or finding that insurers can dictate their care. We’ve also witnessed providers entrapped in endlessly malfunctioning insurer bureaucracies. And these are results that have occurred before these insurers gain enough market share to flip their “open” networks to closed ones.

The Centers for Medicare and Medicaid Services (CMS) should be required to (1) mandate complete disclosure of benefits before enrollment, (2) hold all MA plans accountable for their actions with beneficiaries and providers by establishing a set of publicly reported minimum performance standards, and (3) establish clear pathways for beneficiaries and providers to register complaints and to correct problems.

As regards to the Private Fee-For-Service variant of MA most common in rural Wisconsin, CMS should also require them to (1) offer cost-based providers the choice of a cost settlement or their interim rate plus a fixed percentage, (2) participate in quality of care reporting comparable to local health plans and providers, and (3) protect the beneficiary’s right to access local services such as swing beds as they are needed.

Wisconsin Insurance Commissioner Sean Dilweg hit the nail on the head when he testified last May before the Subcommittee on Health of the House Committee on Ways and Means. “We need the ability to hold companies responsible for the acts of their agents in Medicare Advantage as we currently have for all other insurance products... consumers should be able to go directly to their state insurance departments to resolve problems, rather than having to call CMS who seems to have neither the manpower nor the expertise to deal with many of these types of complaints.”

MIPPA now requires that PFFS plans in counties with several plan choices must create provider networks, PFFS plans in rural areas without other plan options can continue to operate as they do today. This change makes the role of “community access standards” more critical than ever to rural Medicare beneficiaries and providers.

The PFFS plan may have discretion in setting payment rates for contracted and deemed contracted providers. A Medicare PFFS plan can establish payment rates that are less than traditional Medicare for designated types of providers if the plan demonstrates to CMS that it has a sufficient number of providers of each such type under written contract to meet Medicare access standards. CMS assesses the sufficiency of a PFFS plan’s contracted network on the same basis as network sufficiency for a coordinated care plan.

The Central Role of the Robust Enforcement by CMS of “Community Access Standards”

The following is from The 2007 “Report to the Secretary: Rural Health and Human Service Issues” from the National Advisory Committee on Rural Health and Human Services, January 2007:

“The MA program statutes and regulations require that CMS ensure that plan enrollees have reasonable access to covered services, and CMS has emphasized its commitment to providing that access. How CMS and MA plans interpret what is “reasonable” access by beneficiaries to local health care is critically important to rural beneficiaries and providers as well as to the acceptance of MA plans in rural communities. The past operational policy of CMS has supported using community access standards when making network adequacy determinations. As made explicit in the CMS Medicare Managed Care Manual: “Plans must...ensure that services are geographically accessible and consistent with local community patterns of care.” This policy did not change with the advent of MA, but the Committee has not been able to determine how or whether CMS is enforcing this provision with PFFS plans.”

“If beneficiaries enrolled in an MA plan are not well informed about their rights to access care locally, they are less likely to exercise that right. If CMS does not diligently monitor and enforce plan compliance, plans will have significantly less incentive to contract with a region's rural providers, undermining the rural health infrastructure in that region's communities. As long as the current uncertainty and lack of transparency regarding access and network adequacy persist, rural beneficiaries and the providers that serve them will be less likely to consider MA plans a viable alternative to traditional Medicare.”

“The Committee is further concerned that lax enforcement of network adequacy will discourage MA plans from contracting with rural providers. Due to their low patient volumes, the fixed costs of operation are high for many rural providers. As a result, rural providers may require payment rates above those offered in urban areas in order to remain in business. Also, there are generally few providers in rural areas. Without the ability to guarantee increased volume in return for lower payment, it can be difficult for plans to negotiate low rates if rural providers are necessary for the plan to meet network adequacy requirements. The Committee believes that this is what contributed to M+C being a largely urban-specific model. If health plans are allowed weak networks of providers in rural areas, plans might steer rural beneficiaries away from their established health care providers. This could force some to commute a greater distance to new providers, in the process disrupting the web of provider linkages that have traditionally treated those beneficiaries and other rural residents.”

IV. Invest in Healthy Communities

The National Perspective—The American Hospital Association (AHA) is definitely on target when they call for America’s hospitals to get serious about individual and community wellness. They have been circulating a “framework for reform” that puts a significant emphasis on healthy communities. *“Health for Life, Better Health, Better Healthcare”*—a set of goals and an agenda for creating better, safer, more affordable care and a healthier America. While it is described as a “work in progress,” the AHA’s recognition and advocacy for hospitals to go well beyond a traditional medical role is much needed.

From AHA: “Without change, America’s healthcare capabilities and finances will be overwhelmed. As a society we must: provide access to education and preventive care, help all reach their highest potential for health and reverse the trend of avoidable illness. As individuals we must achieve healthier lifestyles, take responsibility for our health behaviors and choices and each one of us must take action...”

Chronic illness is on the rise, half of Americans have one or more chronic illnesses; 80% of spending is linked to chronic illness, much of this is avoidable; obesity has doubled; diabetes is on the rise... Not all illness is preventable. But good primary care, health education and a healthy lifestyle are essential to improving health. Costs for health coverage and healthcare can be controlled as health improves.”

Real reform must address universal access to healthcare and yes, the cost of healthcare. But equally important, it must focus on what individuals and communities can do to become significantly more healthy and less dependent on what will always be very expensive medical interventions. To do less is not reform, but a collective self-deception we can’t afford.

Rural has a unique opportunity to help lead the country in this regard. The following is from “It Takes a Community, Rural hospitals may have an edge in improving population health” by Jessica Zigmond in *Modern Healthcare*, 6/12/06:

“As the federal government pushes the healthcare industry to adopt pay-for-performance, rural hospitals could have an advantage over their urban counterparts in one area: working collaboratively to improve the overall health of their community populations. ‘Pay-for-performance is a payer-driven initiative,” says Tim Size, executive director of the Rural Wisconsin Health Cooperative, Sauk City. ‘We’re in a reactive mode, and haven’t had anything to react to yet,’ he says of rural hospitals.”

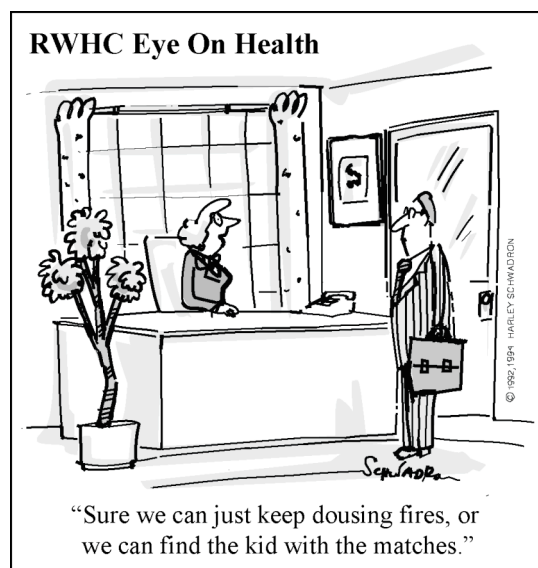
“Terry Hill, executive director of the Rural Health Resource Center in Duluth, Minn., says one of his organization’s goals is to educate rural hospitals on this issue. ‘There is no question that this is where the federal government is going,’ Hill says. ‘What we’re trying to tell rural hospitals is you have to develop capacity to measure your information and get ready for pay-for-performance.’ “

“As rural hospitals learn more about traditional pay-for-performance initiatives, they might consider a concept that was introduced in the spring 2006 edition of the *Journal of Rural Health* and discussed at the National Rural Health Association conference in Reno, Nev., in May. Rural hospitals, with their well-established communitywide relationships, could lead efforts to involve other community players such as local businesses, clinicians, schools and employers in improving a population’s overall health.”

“The article emphasized that ‘the issue is not whether or not rural hospitals should be in charge, but whether or not rural hospitals have a collaborative leadership role to play.’ David Kindig, one of the article’s three authors, says factors besides healthcare are needed to keep a community healthy.”

“ ‘Ten years ago, most people were still in the mode of thinking that healthcare is the most important determinant,’ says Kindig, who serves as professor emeritus of population health sciences at the University of Wisconsin School of Medicine and Public Health. ‘The social factors, like education, income and individual behaviors could be right up there with medical care in terms of their impact on health outcomes.’ “

“Kindig acknowledges that ‘the jury is still out’ on how well this concept will work, especially given that connect-



ing different sectors in the community is not an easy task. ‘You really need people talking to each other from the school board, the community board, and the county board on maximizing the balance of the portfolio across these sectors for population health improvement.’ “

“Hilda Heady, executive director of the West Virginia Rural Health Education Partnerships-Area Health Education Centers, says it is possible for rural hospitals to work with other members in the community to improve a population’s health. The purpose of Heady’s group is to help retain West Virginia-trained health science graduates in underserved rural West Virginia by creating partnerships with the community, higher education, providers and government.”

“ ‘Rural communities are very accustomed to having to collaborate with limited resources,’ Heady says. If applicable, rural hospitals should link with the higher education institutions in their states, Heady says. In West Virginia, medical students in state-supported schools are required to complete three months of their training in any discipline in a rural community. ‘When you look at resource-limited communities, you don’t have the luxury of thinking in silos,’ Heady says. ‘You have to collaborate to survive.’ “

“Size, who served on the Institute of Medicine’s Committee on the Future of Rural Health, worked on a report that culled the six quality aims the IOM introduced in its publication *Crossing the Quality Chasm* in March 2001. Those aims—safety, effectiveness, patient-centered care, timeliness, efficiency and equity—can also be applied when trying to improve rural health, where the entire community is seen as the patient (consequently, the committee changed ‘patient-centered’ to ‘community-centered’). Size says community leaders in business, faith organizations, public education and local government can work collaboratively to improve the overall health of a community.”

“Size, Kindig and third author, Clint MacKinney, outlined steps for rural hospitals to start promoting population health awareness and to establish collaborative efforts, such as adding board members with interests or expertise in population health measurement and improvement, including public health professionals, educators and economic development experts. Hospitals can also devote a periodic board meeting or a portion of every meeting to review available population health indicators, and create a ‘population health’ subcommittee of the hospital board to explore opportunities for hospital partnerships with other community organizations.”

“ ‘Health status is overwhelmingly not a function of healthcare but of (individual) behaviors and socio-economic conditions,’ Size says. Bruce Behringer, assistant vice president for the division of health sciences at East Tennessee State University, Johnson City, supports the idea, says hospitals have both an economic interest and social responsibility in a community. ‘If in fact a hospital in a rural community—which is typically the largest employer—can take the benefit from being funded by tax dollars, there should be some sense of relationship between what happens in the quality of that hospital and the community,’ Behringer says.”

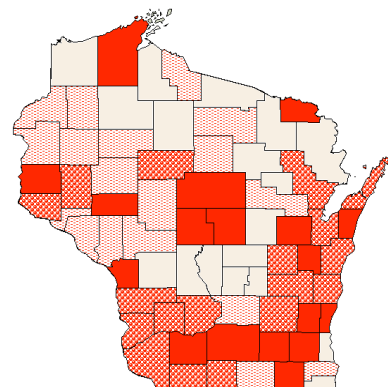
Examples from Wisconsin—Each summer, the University of Wisconsin Population Health Institute reports on “Wisconsin County Health Rankings.” This county by county comparison of health is unique in the view it gives us of our state—it is intended “to summarize the current state of health and distribution of key factors that determine health.” Like any report of this type, there are limitations and the reader is left with as many questions as answers. Which is the point—the report isn’t intended to be the last word, but to begin long overdue local community conversations.

What struck me this year is that the report has two halves, that must be seen as complementary. Not made explicit, but easy enough to calculate is the following: three-quarters of Wisconsin’s urban coun-

ties have health outcomes that are better than average while only one-third of rural counties can say the same. At first glance, not a rural health success story. But before rural Wisconsin healthcare providers get defensive, let's look at the rest of the story.

In addition to calculating “health status” the report also shows a ranking of key factors that are thought to determine health status in each county. The ranking is based on the University’s best guess of the relative weight or importance of four key factors: 10% for healthcare, 40% for health behaviors, 40% for socio-economic factors, and 10% for the physical environment. When you look at these rankings, three-quarters of Wisconsin’s urban counties have health “determinants” that are better than average while only one-third of rural counties do. If you follow the math, there is a simple bottom line; rural counties are predicted to have worse health status and they do. Because individual behaviors like smoking and exercising matter, as do education, jobs and income—the cumulative effect can be, quite literally, deadly.

Rural Wisconsin Expected To Have Lower Than Average Health & It Does



Worst Quartile (white) Second Quartile (red)
Third Quartile (redder) Best Quartile (reddest)

Calculated from the 2007 “*Wisconsin County Health Rankings*,” University of Wisconsin Population Health Institute

Does this let rural healthcare providers off the hook? I don’t think so. It just means we have a large hook with plenty of room for company. Some “healthcare reform” advocates figure if everyone has health insurance and healthcare providers can be properly “controlled,” problem solved! As one prominent state supporter of single payer healthcare once asked me, “what am I supposed to do, campaign door to door and tell folks to ‘drop the donut.’” “No, but we need to get real. Healthcare reform isn’t health reform. What we care about is our health and the health of our family, friends and neighbors. It is the lack of community health that drives costs that we increasingly can no longer afford.

V. Summary

Rural health provides care to smaller communities at some distance from larger urban hospitals and clinics. We do so even as patients are attracted or forced out of town. We struggle with the power of huge public and private healthcare insurers. Federal “anti-trust” laws were written to protect communities against powerful monopolies. Now they seem to help for-profit giants over communities by limiting our ability to cooperate with each other.

Laws have long required insurers to respect the right of people to receive healthcare locally. These laws will continue to be stretched and tested. Congress is likely to continue its experiment to offer Medicare through for-profit insurers known as Medicare Advantage plans or Medicare HMOs. Protecting access to local care must be a high rural priority.

The soon to explode retirement of baby boomers will lead to a critical shortage of workers. Our current approach to growing the next generation of doctors, nurses, pharmacists and therapists makes Katrina look well handled. Think Keystone Cops. We don’t know where we need to go or how to get there but

we look sincere and very busy. Many rural communities already face staff shortages. But when it starts raining in the suburbs, expect a tsunami “outstate.”

Reform is about people getting the care they need at a cost our country can afford. Equally important, reform must help individuals and communities to become healthier, to not need as much healthcare. If the growing need for care is not reduced, costs will explode, whatever the reform.

Unlike Lake Wobegon, two out of every three counties in rural Wisconsin are less healthy than average. This is not because of poor rural healthcare. It is due to too much smoking, drinking and eating. It is due to too little exercise, education, jobs and income. Reform without the bigger picture will fail.

And at the very least, healthcare reform must lay down a road map to make our seniors and communities as healthy as we know they can be.

In summary, healthcare reform must address factors unique to the rural context and achieve the following:

- ✓ Make the Health Workforce a Priority
- ✓ Hold Medicare Advantage Plans Accountable
- ✓ Invest in Healthy Communities

Thanks.