Enough is Enough: Operation MASH

By Tim Size, Executive Director, Rural Wisconsin Health Cooperative (RWHC), Sauk City

Since last fall and throughout our very long winter, rural hospital CEOs and advocates in Wisconsin have been traveling to Washington, DC, on an almost monthly basis to meet with members of our Congressional Delegation. We have been doing this not to rack up frequent flier points but to keep rural hospital issues front and center during a time of significant uncertainty in Washington. The threats we face fall into two buckets, one from Congress and one from the Administration.

All rural and urban hospitals are at risk for ongoing Congressional cuts related to health reform and the Federal budget deficit. Our message is the same as the Wisconsin Hospitals Issue Advocacy Council: “Enough is Enough.” We, along with the Council, know that “we have some of the best hospitals in America. Study after study shows our hospitals are tops in quality of care and creating value… but in Washington, they keep cutting Medicare payments to hospitals—across-the-board cuts that hurt leaders like Wisconsin the most.”

The second bucket is unique to rural and affects rural hospitals nationwide. And it feels a lot more personal. It comes not from Congress but from the Federal Department of Health & Human Services (DHHS) and in particular the Centers for Medicare and Medicaid Services (CMS). Rural hospitals feel under siege, and unlike most urban hospitals, believe that there is a deliberate campaign by the Federal government to drive them out of business.

Examples from recent months include a report from the DHHS Office of the Inspector General’s (OIG) report calling for the elimination of Critical Access Hospital (CAH) status for most rural hospitals, the capping of stays at CAHs to four days and the imposition of totally unneeded and undoable physician supervision requirements.

The underlying “attitude” behind these regulatory assaults is not new and not dependent on the Party in control of the White House. While it appears to be a problem that comes and goes, we believe it is deeply entrenched within DHHS and in particular within CMS.

About nine years ago, when we were involved in an effort to clarify the rules for when a CAH could relocate, we discovered how embedded the anti-rural hospital sentiment is within CMS. Not one but two individuals from within the agency relayed a senior staffer’s opposition to rural hospitals by quoting her as saying: “there is no need to rebuild old rural hospitals when we have Army Surplus MASH Tents.”

(For younger readers, MASH stands for Mobile Army Surgical Hospitals. They were used during the wars in Korea and Vietnam and popularized by a television series of the same name.)
During our February visit with Members of Congress, we talked about the demoralizing consequences of rural hospitals being relentlessly battered by DHHS and CMS. In one visit, before we could get into the swing of it, the Congressman interrupted us, threw out his arms and exclaimed: “ever since I’ve been here I’ve seen they really don’t like you guys!”

That was a galvanizing moment for us when we decided enough already—that we needed to stop playing defense and go on the offense. Rural hospitals lie at the heart of rural health and its future. Across our state and across our country, colleagues work tirelessly to serve rural communities to keep local care local. We owe them to no longer be silent.

Rural hospitals have much to be proud about. “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 communities than in urban ones, and rural hospitals perform better than urban hospitals on three out of the four cost and price efficiency measures on Medicare Cost Reports.” Ironically, these observations don’t come from some unscrubbed backwater advocate but from a recent policy brief by the National Advisory Committee on Rural Health and Human Services–advisory to the Secretary of Health and Human Services who is ultimately responsible for CMS.

We need a cross section of DHHS and CMS leadership and rural health leaders to sit down and openly address the engrained attitudes on “both sides” that appear to have fueled an antagonistic relationship over too many years. We need to resolve how “both sides” can work together collaboratively to the same end of guaranteeing reasonable access to quality local health care and jobs in rural America.

Upper Midwest Tops in Medicare Advantage

From “2012 Rural Medicare Advantage Quality Ratings and Bonus Payments” by Leah Kemper, Abigail Barker, Timothy McBride and Keith Mueller in a RUPRI Center for Rural Health Policy Brief, 01/14:

“The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from traditional fee-for-service Medicare. MA and other prepaid plans, increased to over 14.5 million as of March 2013 (28.2% of all Medicare beneficiaries), including 1.9 million rural enrollees (18.6% of rural Medicare beneficiaries). The Patient Protection and Affordable Care Act of 2010 established bonus payments to reward plans with high quality ratings (4 stars or higher) beginning in 2012.”

“The star ratings of MA plans are now both a tool for beneficiaries to use to compare plans and a source of additional payment for plans. On average, rural MA plans typically have lower quality ratings than urban plans resulting in lower quality based payments. This brief analyzes data to measure these differences in quality and payment and suggests reasons why quality ratings vary by geography. Key findings are as follows:

- The average rural MA plan enrollee in 2012 experienced a quality rating of 3.60 stars (of a potential 5.0), compared with a rating of 3.71 stars experienced by urban enrollees.

- The measured rural-urban difference in the MA plan quality is a result of the difference in the composition of the enrollment and plan availability in MA markets, rather than differences between MA plans of the same type.
Rural Medicare beneficiaries often have limited MA plans available from which to choose, and typically have lower quality ratings than urban MA plans.

Rural MA beneficiaries are more likely to be enrolled in preferred provider organization (PPO) plans than in health maintenance organization (HMO) plans.

PPO plans have lower quality ratings on average than HMO plans.

HMO plans had the highest average quality rating at 3.83 and 3.78 stars, respectively, in rural and urban areas. PPO plans had lower quality ratings, at 3.52 and 3.50, respectively.

In rural areas, 32% of the MA population is enrolled in a plan with a star rating of 4.0 or higher, and 92% are enrolled in a plan with a star rating of at least 3.0, as contrasted to urban enrollment of 36% and 94% respectively, making these plans eligible for quality based bonus payments.

The quality rating of rural MA plans varies significantly across the country, with the highest quality ratings in rural areas in Minnesota, Iowa, Wisconsin, Oregon, Pennsylvania, and Maine."

Rural Hospitals Can Lead in Rural Health

From the commentary “Population Health Improvement & Rural Hospital Balanced Scorecards” by Tim Size, David Kindig, and Clint MacKinney in the Journal of Rural Health, Spring, 2006:
“Now is the time for Balanced Scorecard driven strategic planning to incorporate population health measures. The growing expectation of healthcare providers regarding health improvement and healthcare costs suggest that healthcare providers join with public health and other community leaders to ‘look upstream’ for opportunities to prevent illness and reduce future healthcare expenses. Community leadership must act, and hospitals are part of that leadership. The Balanced Scorecard is a practical performance improvement tool that rural hospitals are increasingly integrating into their strategic planning and management processes.”

“The goal of the Balanced Scorecard is to link strategy with action and to identify cause/effect relationships among short and long-term objectives. Robert Kaplan and David Norton helped to popularize Balanced Scorecard in the early 1990s and they organized key objectives into four domains: Financial, Customer, Internal Processes, and Learning and Growth. Since then, strategic planning consultants and hospital leaders have been adapting, applying, and evolving the tool for healthcare.”

“David Kindig and Greg Stoddart define population health as ‘the health outcomes of a group of individuals, including the distribution of such outcomes within the group.’ These populations are often geographic regions, such as nations or communities, but they can also be other groups, such as employees, ethnic groups or disabled persons. Such populations are of relevance to policymakers. In addition, many determinants of health, such as medical care systems, the social environment and the physical environment, have their biological impact on individuals in part at a population level.”

“Many hospitals, across the country, have long been involved in key community-wide interventions—this is not new. However, the concept of including local population metrics in a hospital’s Balanced Scorecard is challenging because hospitals, not unlike other community organizations, are not solely responsible for their communities’ health. As best expressed by a rural hospital CEO during a focus group discussion at the Rural Wisconsin Health Cooperative in early 2004, when population healthcare outcomes are everyone’s responsibility, it is, as a practical matter, no one’s responsibility.”

“If some entity(ies) must step up and take leadership in the quest for optimal health, the healthcare sector has significant responsibility and opportunity—a responsibility given the nature of the profession and the significant amount of public and private resources it is entrusted with (not to mention its legal community benefit responsibility), and an opportunity given the trust that most people put in healthcare providers and organizations. If this is true, rural hospitals may have an opportunity to take a lead given the smaller size of the organization, the general interrelatedness of the different sectors in rural areas (healthcare, education, social services, public health, local government), and the importance of the rural hospital and health systems in the local economy.”

“The very essence of Balanced Scorecards is that successful organizations focus on those objectives and related outcomes, that if achieved, go a long way to advancing the organization’s vision. If organizational success is directly affected by measures of population health, hospitals will engage. But hospitals don’t print money and few rural hospitals have separate foundations with any substantial resources. The challenge is as it has always been, how do we pay for caring for today’s patients while finding the funds to become more proactive to reduce the future healthcare needed.”

“If cultural barriers to population health improvement were not difficult enough, technical barriers, while narrower in scope, remain challenging. Most metrics found to be useful for Balanced Scorecards are measured on a monthly or quarterly frequency. Consequently, results of interventions aimed at moving the data can be tracked and used to test intervention effectiveness, identify unintended consequences, and motivate...
change. In contrast, traditional population health metrics are available annually at best and typically represent a geographic area that does not align with a hospital service area. In rural service areas, the above barriers are further complicated by the statistical challenges of working with small numbers. We need new approaches to address these data gaps.”

“In the meantime, where do we start? Much can be done at the local level by rural hospitals to foster population health awareness and new collaborative interventions, such as:

- Devote a periodic Board meeting or a portion of every Board meeting to review available population health indicators.
- Add Board members with specific interest and/or expertise in population health measurement and improvement.
- Create a ‘population health’ subcommittee of the hospital board to explore opportunities for hospital partnerships with other community organizations to improve proactively population health.
- Consider hospital employees or employees of a proactive local employer as a ‘community’ and develop interventions to improve employee health. Then, expand the experience to the larger community.”

“Business schools cite railroads as a classic example of a sector’s failure to adapt to changing times; falling from tycoon status in the late 19th century to bankruptcy in the 20th. The railroads kept on doing what initially had been a successful business strategy – selling access to rail cars and track. However, the railroads failed to adapt to a market that was redefining transportation as cars and airplanes, not trains. In a similar fashion, healthcare ‘markets’ are being redefined; shifting from purchasing service units to purchasing quality outcomes. Importantly, quality care is increasingly defined in both personal and population perspectives. This developing redefinition of healthcare markets needs to be reflected in hospital strategic planning. This is a great opportunity for rural hospitals and the communities they serve.”

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**Responsible Public Reporting**

From “Guiding Principles for Public Reporting of Provider Performance” by the American Association of Medical Colleges ([www.aamc.org](http://www.aamc.org)), 3/3/14:

“The number of organizations issuing reports on hospital and physician quality performance has increased remarkably over the past decade. Differences in the measures, data sources, and scoring methodologies produce contradictory results that lead to confusion for the public, providers, and governing boards, and impair the public’s ability to make well-informed choices about health care providers.”

“A paper published in *Health Affairs* (2008), showed markedly divergent rankings of the same institutions by Hospital Compare, Healthgrades, Leapfrog Group, and *U.S. News & World Report*. This variability continues today and points to concerns about validity and reliability among the measures used by these groups.”

The hospital community supports the principle of accountability through public reporting of health care performance data. However, performance data that are not collected, analyzed, or displayed appropriately may add more confusion than clarity to the health care quality ques-
tion. For data to be understood and for results to be comparable, publicly reported data should adhere to a set of guiding principles. With that goal in mind, the American Association of Medical Colleges convened a panel of experts on quality reporting to develop a set of guiding principles that can be used to evaluate quality reports. The principles are organized into three broad categories: Purpose, Transparency and Validity.”

**Purpose:** “Public reporting and performance measurement occur for a variety of reasons, including consumer education, provider quality improvement, and purchaser decision making. Each website that reports performance data should explicitly state its target audience and the intended purpose of the report. The data, measures, and data display should fit the report’s stated purpose. Stakeholders may have differing opinions on how well the measures and methodology meet the intended purpose; however, a discussion on divergent viewpoints cannot occur if the purpose is not well defined.”

**Transparency:** “Methodological details can impact both providers’ performance data and the appropriate interpretation of the data. Transparency requires that all information necessary to understand the data be available to a reader; this information includes measure specifications, data collection methods, data sources, risk adjustment methodologies and their component parts, composite score methodologies, and reporting methods used to translate results into graphical displays. Details should be sufficient for independent replication of the results. Limitations in the data collection and methodology and relevant financial interests also should be disclosed.”

**Validity:** “Validity ensures that the methodology, data collection, scoring, and benchmarks produce an accurate reflection of the characteristic being measured. Ideally, measures, as well as composite and scoring methodologies, should be supported by clinical evidence, field-tested and, where appropriate, have National Quality Forum endorsement. Validity is necessary to ensure that results are accurate and that providers are appropriately characterized.”

“Public reporting that adheres to these guiding principles will ensure appropriate interpretation of performance results.”

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**RWHC HCAHPS Reporting Service**

**Are you taking the pulse of your Patient’s experiences?** If your Hospital is exploring options for participation in HCAHPS reporting, it is important to consider all of the issues when choosing a vendor. The Rural Wisconsin Health Cooperative (RWHC) is owned and operated by 40 rural med/surgical hospitals in Wisconsin, so we understand how rolling out a new program can be a challenge and we make every effort to ensure the transition is as worry free as possible.

RWHC knows Rural. We’ve been working for smaller hospitals since 1979. We know that “ease of use” is paramount to getting the job done in a timely and efficient manner. Our patient satisfaction surveys are designed with you in mind! Contact us to learn more about our HCAHPS, Outpatient, ED, or other experience and satisfaction surveys.

- Upload files at your convenience (biweekly, or monthly)
- All functions occur on a secure website; no software to purchase or maintain
- Surveys are mailed daily, so you don’t have to wait for your information
- No hidden fees for technical assistance, education, reports or follow up mailings
- Reports are updated daily and available online

Before making a choice about which vendor you will utilize, make sure you understand how the vendor will support you during this process. RWHC has highly trained expert staff ready to provide the highest level support you during this process.

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/ejm1f](http://ow.ly/ejm1f) to learn more.
of customer service available. Give us a call so we can help you get started today; contact Mary Jon Hauge at 800-225-2531 for more information.

Leadership Insights: “Sacred Cows”

The following is from RWHC’s Leadership Insights newsletter by Jo Anne Preston, RWHC Organizational Development Manager. More at www.RWHC.com.

“We see them in others: the boss’s pet project that no one dares to question. Your co-worker who reports to a relative and isn’t held accountable because of the stress it would cause at family gatherings. A colleague with an ‘under the gun’ style of work puts everyone else in a tailspin, but insists their creativity cannot be encumbered by others’ time frames.”

“People, projects and styles of work that operate above reproach are what we refer to as ‘sacred cows.’ Working around someone’s sacred cow leaves people feeling frustrated and powerless. At their extreme they can increase turnover and derail careers. At minimum they reflect poorly on the leader who may not even be aware that they are being seen as having one.”

“Our last leadership book study discussion, What Got You Here Won’t Get You There, by Marshall Goldsmith, challenged readers to consider that work styles and habits that used to be effective for us may no longer be so as we progress in our leadership journey. When it comes to sacred cows, left unexamined, most of us will initially think of what we have seen in others. But what about our own ‘untouchable’ people, projects and style of work? You might be surprised to realize that you have some–most of us do.”

“An Alcoholic’s Anonymous slogan advises, ‘Don’t take other people’s inventory.’ We are much better served to take our own to see how we might be getting in our own way, and looking at our sacred cows could be a good place to start.”

“Think about why we have sacred cows. They may have a very positive origin:

- We have specific things we are passionate about.
- We appreciate what others can do that we cannot.
- We want to make our mark.
- We desire to make best use of our strong suit.”

“But any of us can lose perspective over time. If that happens:

a) Keep your passion, but look for and listen to data that might tell you when, regardless of passion, it might be time to try something different. Passion is a powerful motivator and strength, but alone it is not enough to get the results for an organization to be successful. Think passion with a plan (that includes markers of when it’s not working) and genuine buy-in from others. Do you have both?

b) Continue to recruit those who can do what you can’t—this is a way to build a strong team. While doing so, be careful that you are not abdicating your responsibilities to avoid work that you don’t like or are afraid you can’t do. This can result in allowing underperformance in that individual’s other important job performance skills because of the unique function they take care of for you. If there is someone you find yourself defending, either verbally or in your own mind, it might mean that you have made allowances for one person that you wouldn’t for someone else.

c) Do work that makes a difference! Then remember that most legacies are not a solo flight, especially in health care. If you have a pet project, keep people on your team who will be honest
with you about when it might be time to make a change. As a leader, you have to assume that most people are just not going to approach you and say, ‘Hey you know that project that you are so stoked about? We think it is a bad idea.’ Thank people who help you and who also take the risk to share a different point of view with you.

d) Do know and use your strengths and realize that your strengths may be someone else’s headache. Write a paragraph about your work style and habits. Ask someone you work with and trust to write a paragraph about your work style and habits. Where do—and don’t—they line up? Perhaps you both write that you are creative and you deliver. However, the other writer’s take is that your creativity often means change at the last minute, which is when you usually deliver and that impacts other’s work flow in a less than positive way causing stress and uncertainty.

e) A friend of mine told me that in his earlier life he was a dirt bike racer. His motto was, ‘If you aren’t crashing, you’re not trying.’ When we can’t question something, or humbly admit that we might need to adapt, it throws a bottleneck into the workplace and stifles innovation. Thank the people who question you; it will help prevent you from being part of that bottleneck.”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series 2013 go to www.RWHC.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.”

Upcoming RWHC Leadership Programs

April 3: Lateral Violence: Empowering Staff to Stop Bad Behaviors
May 5: Hiring the Right Person for the Job (held in St. Croix Falls)
May 22: Refueling the Heart: Are You Running on Empty?

To register or see other upcoming events, go to: www.RWHC.com/Services.aspx

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