Rural as Bellwether for American’s Safety Net

From “Rural hospitals: On the critical list?” by Ruth Ravve at www.FoxNews.com:

“‘It’s been ‘probably a decade’ since 68-year-old Tom Howell last saw a doctor. A nagging cough and some chest pain finally prompted him to drive 30 miles from his home in Iowa to the closest medical facility, Midwest Medical Center in Galena, Illinois.”

“‘I’ve been coughing so hard I couldn’t catch my breath. My wife said I had to see the doc, so here I am,’ Howell said”

“He said part of the reason he avoided seeing ‘the doc’ for so long was because he didn’t have health insurance. As a self-employed farmer in Iowa, he couldn’t afford it and said he didn’t see a need for it.”

“But he’s now on Medicare, so doctors bills are less of a concern. The U.S. Department of Agriculture estimates more than 46 million Americans live in rural areas, working on farms or in small factories that provide resources for the rest of the country.”

“Often in these less populated areas, there is only one medical facility for the entire community. Much of the funding for rural hospitals, about 60 percent, comes from Medicare. The rest comes from Medicaid or from general health insurance.”

“Budgets are so tight for these smaller hospitals, where patients are often older and sicker than the general population, that any changes in Medicare or Medicaid—even slight changes—can have drastic effects on their budgets.”

“That’s why recent cuts by the Obama administration for Medicare reimbursement funding are a grave concern to rural healthcare administrators. In addition, there’s an October deadline for upgrading to electronic medical records. If the deadline isn’t met, hospitals risk penalties.”

“But making the upgrades is not as simple as it sounds, especially for smaller medical offices that are still on pen and paper.”

“‘Going from paper to electronic medical records is a big process,’ said Dr. Michael Wells of the Midwest Medical Center in Galena. ‘It takes a lot of personnel and staff and support for information technology just alone, so it’s a huge task for a smaller hospital when we don’t have the number of employees to support that.’ ”

“Midwest Medical Center CEO Tracy Bauer agreed. ‘It’s a huge undertaking. We’ll have invested over two million dollars in the project… The expense needed for it have been huge.’ ”

“The combination of Medicare cuts and the added expense of transferring to electronic records is part of the reason there has been an epidemic of rural hospital closures. Eighteen have shut since the beginning of 2013, more than closed in the entire decade before then.”
“‘Regulations are always changing, and you look at additional cuts, you look at the federal budget, you look at the state budget and you don’t know when that next cut is going to be’ said Bauer. ‘It’s the difference between you being able to provide access in a rural area to not being able to.’”

“When rural hospitals close, residents are left with no easy alternative for medical care. Often a drive to a doctor for a checkup can take more than an hour. In an emergency situation, the distance can be a matter of life or death.”

“We’ve saved lives by being here and providing that access here, and a lot times if we’re not here, those people unfortunately would not make it in time to the stop that they need to be at, so it’s really critical that we’re here, able to provide that care,” said Bauer.”

“Care is provided to anybody, regardless of their ability to pay, at many of the critical care centers, which is another reason finances are so tight.”

“The Affordable Care Act was supposed to alleviate that problem by providing the poor with health insurance and reducing the number of uninsured going to emergency rooms for expensive treatment.”

“But health experts claim that’s not always working out so well.”

“Brock Slabach from the National Rural Healthcare Association said often poorer people choose the least expensive option among the plans provided under ObamaCare, but still can’t afford to pay the deductibles required before doctor visits are covered. As a result, those patients don’t go to the doctor regularly, but instead run to the emergency rooms when a medical issue becomes a crisis.”

“It is the same costly problem that existed before ObamaCare went into effect. Rural hospital administrators worry the trend of closing hospitals will continue as rules and regulations continue to change.”

“It is not just the loss of healthcare providers in a community when a rural hospital closes, there also is an economic impact. Medical facilities are often the biggest employer in the countryside, so when one closes, a downward financial spiral for the community begins that could quickly spread into more populated areas.”

“The National Rural Health Association warned the fate of rural hospitals is a bellwether for the nation’s healthcare system. ‘I think your rural hospitals are going to be the canaries in the coal mine that lead to disaster for hospitals all over if we continue some of our current trends’ Slabach said.”

“He called it a domino effect: when rural communities suffer, the whole country suffers. ‘The sustenance of our country’s health and well being is produced in the rural areas of our country,’ he said. ‘The second we begin to dismiss that is the second that we’re going to be very regretful of having lost those resources.’”

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Congratulations to WHA’s Quality Team

The Wisconsin Hospital Association (WHA) is slated to receive the 2014 Dick Davidson Quality Milestone Award for Allied Association Leadership for its work to improve health care quality, the American Hospital Association (AHA) recently announced.

The award, given to state, regional or metropolitan hospital associations that demonstrate leadership and innovation in quality improvement and contribute to
national health care improvement efforts, will be presented in July.

“Improving quality and patient safety is a never-ending quest for America’s hospitals and health systems,” said Rich Umbdenstock, AHA president/CEO, noting that Wisconsin’s efforts “exemplify the key role now played by hospital associations across the country in convening and supporting their members in the critical work of quality and safety collaboratives.”

According to the AHA, WHA demonstrated a comprehensive quality portfolio supported by strong leadership and governance. Along with 108 of its member hospitals, WHA developed strategic partnerships to advance quality care statewide. One example of their success was to prevent a recently discharged patient from an unplanned return to the hospital within 30 days. WHA and their hospitals successfully reduced readmissions by 22 percent, exceeding the government’s goal of a 20 percent reduction. This eliminated readmissions for more than 3,500 patients and reduced health care spending by more than $34 million.

WHA also worked with birthing hospitals in Wisconsin to reduce Early Elective Deliveries (EED), or babies born at the request of the mother or for non-medical reasons before 39 weeks gestation. Since mid-2012, Wisconsin hospitals have reduced EEDs by 78 percent, with an associated estimated cost savings of more than $210,000.

“Wisconsin is a recognized leader in health care quality and value. Our goal is to ensure that every patient in our state receives the finest care possible no matter where they go for that care. Through our collaboration on quality improvement, that goal is in range,” said WHA President Steve Brenton. “As much as hospitals have been able to significantly improve care, however, Wisconsin health care leaders are keenly aware that their work is far from over.”

The award is named for AHA President Emeritus Dick Davidson, who strongly promoted the role of hospital associations in leading quality improvement during his tenure as AHA president and as president of the Maryland Hospital Association. Wisconsin and the Connecticut Hospital Association were the only two state hospital associations to receive the award this year.

Narrow Networks Toss Rural with Bathwater?

From “More Insured, but the Choices Are Narrowing” by Reed Abelson in The New York Times, 5/12/14:

“ ‘We have to break people away from the choice habit that everyone has,’ said Marcus Merz, the chief executive of PreferredOne, an insurer in Golden Valley, Minn., that is owned by two health systems and a physician group. ‘We’re all trying to break away from this fixation on open access and broad networks.’ ”

“But while there is evidence that consumers are willing to sacrifice some choice in favor of lower prices, many critics, including political opponents of the new health care law, remain wary about narrowing networks. A concern is that insurers will limit access to specialists or certain hospitals. ‘Too often, Obamacare cancels the policy you wanted to keep and tells you what policy to buy,’ Senator Lamar Alexander, a Tennessee Republican, said in a speech in April.”

“ ‘The thing you are buying is access to the provider network,’ said Lynn Quincy, a policy expert at the
Consumers Union. ‘Right now it feels like you’re forced to guess.’ In response, regulators say they are more closely monitoring the plans being offered in the coming year to be sure they are clear and that consumers have sufficient access to hospitals and doctors. In some cases, they are already insisting on changes.”

“Nonetheless, for people who are directly picking plans in the open markets, insurers say price is critical. People ‘are weighing affordability and breadth of network,’ said Karen Ignagni, the chief executive of America’s Health Insurance Plans, an industry trade group. ‘What we’re finding is individuals are experiencing a preference for affordability,’ she said.”

“On the state exchange, PreferredOne offered an inexpensive plan with a network of 13 hospitals, but those low premiums helped the insurer grab 60 percent of the individual insurance market.”

“While many insurers are including only those hospitals and doctors willing to charge lower prices, experts say the makeup of the networks is likely to evolve over time, focusing less directly on price and more on the ability of providers to deliver coordinated and high-quality care.”

“Blue Shield of California was able to recruit a fairly sizable group of providers interested in discounting their rates. Just as the plans must compete on the exchanges, ‘the doctors and hospitals are competing with each other to get in,’ said Juan Davila, an executive vice president with the insurer. The next step, Mr. Davila said, is to work with providers to develop networks, where the insurer will team with those doctors and hospitals to provide better care.”

“Outside exchanges, insurers are promoting smaller networks for employers as a way to reduce overall health care costs, said Larry Boress, chief executive of the Midwest Business Group on Health. ‘The larger the network is, the higher the cost,’ he said.”

“Employers remain concerned about the quality of the networks, said Mr. Boress, and many are doing an analysis to see how disruptive changing the network would be for their workers. Nonetheless, the bottom line is that more employers are considering smaller networks. Many, like Walmart and General Electric, have gone so far as to steer employees to specific hospitals for certain expensive procedures like joint replacements.”

“In 2010, 24 percent of the largest employers offered smaller networks, chosen for their low costs or quality. Last year, 27 percent offered them and 44 percent said they were considering them, according to Mercer, a benefits consulting firm. Some companies are experimenting with different tiers of networks, charging workers more if they go to the broadest network, said Joseph Kra, a Mercer consultant.”

“There has been pushback, however. Medicare recently announced it would require Advantage plans to give advance notice of any significant changes to a network and might allow beneficiaries to switch during the year if the network underwent too much change after they had already signed up. Federal officials, who had floated the idea of requiring exchange plans to submit their networks for review, said they would instead focus on specific types of doctors, like cancer specialists, to make sure people have adequate access to care.”

“‘We intend to continue monitoring plans,’ a Medicare spokeswoman said in a statement, ‘and learn from that review, to determine if further rules are needed in the coming years to ensure that plans offer quality networks to consumers.’ ”

“State regulators are also contemplating action. In Washington State, Mike Kreidler, the insurance regulator, issued new rules last month that set certain minimum standards for access to a doctor and require insurers to make clear who is in the network. ‘I want to make sure carriers are not in a race to the bottom,’ he
said. New Hampshire regulators are also trying to weigh in on the decision by the state’s only insurer, WellPoint, to exclude some hospitals. In Washington, Seattle Children’s Hospital is challenging state insurance regulators because some of the plans exclude it. Regulators are also working with insurers to make it clearer which providers are included in a network.”

Not Leaving Our Future Workforce to Chance

“The National Governors Association (NGA) has announced the selection of seven states—Colorado, Indiana, Kentucky, Minnesota, North Carolina, Oklahoma and Wisconsin—to develop and implement statewide plans for their health care workforce.”

“A policy academy is a highly interactive, team-based, multi-state process for helping a select number of states develop and implement plan to address a complex public policy issue. Participating states receive guidance and technical assistance from NGA staff and faculty experts as well as consultants from the private sector, research organizations and academia.”

To learn more about NGA’s health division, please visit www.nga.org/cms/center/health.

RWHC Rural Focused Financial Consultation

RWHC provides rural focused financial consultation to individual hospitals relating to managed care contracting and other financial issues—including Medicare cost report preparation. Our experts will meet with your CFO, administrator or other staff on-site or over the phone, whichever works best for you.

The RWHC Financial Consulting Services offers a wide range of customized options, including the following:

- Per diem CFO support for short term leaves or vacated positions.
- Assistance with budget preparation and financial reporting issues.
- Evaluation of debt financing alternatives.
- Consultation on reimbursement issues.
- Contract review and negotiation.
- Chargemaster evaluation and development.
- Strategic planning for financial performance.
- Educational updates for management, hospital boards, physicians, etc.
- Medicare compliance guidance.

RWHC also has expertise in coordinating retirement plans and external financial audits, including determining RFP parameters and negotiating fees with CPA firms.

For additional information about RWHC Financial Consulting Services please contact Rich Donkle, CPA, at rdonkle@rwhc.com or (800) 225-2531.
Immunization Starts at the Birthing Hospital

The following is by Ann Lewandowski, RWHC Coordinator for the Southern Wisconsin Immunization Consortium (SWIC). SWIC has received additional funding through the Office of Rural Health to help critical access hospitals identify opportunities, best practices, and planning considerations for birthing programs through this August. Assistance is always available, but hospitals are encouraged to take advantage of the grant funding currently available. For questions or comments, please contact Ann at alewandowski@rwhc.com.

As the United States continues to score below other wealthy countries for infant and maternal health indicators, birth immunization programs provide a unique opportunity to reduce the spread of disease, to bend the cost curve and potential liability for hospital-acquired infections. An equal consideration for implementing these programs is our dedication to our community’s health.

These programs can be administered to low-income and minority individuals free of cost creating an opportunity to reduce the burden of disease and health disparities within our communities. As advantageous as these programs are, many small birthing hospitals find that these valuable programs cannot be implemented in their setting due to staffing costs, confusion on how to maintain patient records, and the potential for funding changes. Here are three programs available to birthing hospitals that weigh the potential risk and rewards for implementing each program.

The most well-known and the easiest program for birthing hospitals to implement is the Hepatitis B birth dose program. The program has clear staffing roles and an easily identified place in the hospital setting. The birth dose is administered by the nurse attending the birth and is included in the charges for the hospital admission. Recordkeeping is also simple with consent shown as a notation in the birthing chart and the Wisconsin Immunization Registry (WIR) or other state registry being an important, and sometimes overlooked step. In short, this program is cost-effective and easy to implement with ongoing financial compensation.

A TDaP (tetanus, diphtheria, and pertussis) vaccine cocooning program is slightly more complex with additional planning requirements. To date, TDaP cocooning programs are sponsored through the State of Wisconsin with free vaccine designed to provide protection to infants from the Pertussis (Whooping Cough) prior to their first dose of DTaP vaccine at six months of age.

Whooping Cough is the most serious infectious disease causing significant morbidity and mortality in children. The Wisconsin Immunization Program (WIP) provides free vaccine for birthing hospitals. WIP allows an administration fee of approximately $16. Currently, the State-sponsored vaccine is only available to birthing hospitals, meaning the opportunity for free vaccines cannot be shifted to outpatient settings.

Finally, it is important to highlight a new program available designed to combat skyrocketing measles rates. This is a referral program to local public health. Those most at risk for measles are adults over 30 who only had a single dose of the measles, mumps and rubella (MMR) vaccine. In May of 2014 due to several cases of import-related measles, the State of Wisconsin authorized local health departments to administer MMR vaccine irrespective of age or insurance status. Close contacts of newborns without a second dose of MMR vaccine should be referred to their primary care provider, or in the absence of a primary care provider, to their local health department to obtain a second dose. Local health departments will be able to vaccine
anyone for the duration of the measles outbreak. To take advantage of this opportunity, hospitals should contact local health departments and obtain their hours to ease the referral process.

*The above cartoon is from the International Team of Comics Historians at [http://superitch.com/?p=33605](http://superitch.com/?p=33605) and was extracted from the 1930 cartoon booklet, “Health in Pictures.”*

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**Leadership Insights: “Resting on Our Laurels”**

The *Leadership Insights* series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues available at [www.RWHC.com](http://www.RWHC.com).

“Weaths of laurel leaves worn as a crown in ancient Greece indicated that victory had been achieved, that a high status had been attained. Today, you may see universities using laurels to signify a commencement. It is right and good to acknowledge an achievement! It can be so satisfying—even joyful—to bask a bit in knowing you have done well. But ‘resting on our laurels’ happens when we wear the crown a little too long and complacency can set in. It happens to most of us at one time or another. You may be resting on your laurels if you:

- Claim talent or achievement in something that you are no longer actively working on;
- Feel like you are in a rut of a routine at work;
- Experience work like there is just no ‘movement’ in your progress;
- Are making statements about your area of expertise that are based on practices that you haven’t re-searched for a while;
- Feel a little guilty for saying that you are accomplished at something that you have not kept up with. (Yes, I did earn a black belt in Tae Kwon Do, but I haven’t practiced for about 15 years. I’m probably pretty harmless.);
- Think your best work is behind you.”

“When we do something well, it is tempting to ‘rest on our laurels.’ After all, we achieved something great; why not just hang out there for a while? As with most things, there is a balance to be struck. The flip side of resting on our laurels is when we neglect to celebrate success at all. We jump immediately to the next project without taking time out to recognize others or ourselves for a great result—and we miss the opportunity for a rush of motivation. But settling into wearing the crown is also a problem. When we achieve something great, we raise the bar for ourselves and that is where excellence is born. Put down the crown and:

**Stay curious, especially about what you know.**

“Consider where you catch yourself making strong statements about your profession or ‘the things you know for sure.’ Are you staying open to new things that have been learned since you began to advocate for your position? How do you keep current in changes in research? Encourage people to challenge your thinking by asking ‘what if,’ and being the devil’s advocate.”

**Leaders go first.** “One of our dogs on our walks loves to go around the corner ahead of us when she is off leash. She is not supposed to, but she cannot stop herself. She *believes* she is a leader. Leaders want to see what is around the corner before anyone else, to brave new trails and pave the way for others. Do you take the time to look at what might be ‘around the corner’ before others do? What changes are in store for your profession and how can you begin to anticipate them proactively? Begin your work week with the question, ‘What are we doing that has gone unexamined?’ Then examine it.”

You know who loves you, but who doesn’t? “Many years ago I had 360 reviews completed on my performance and sent the questionaires out to my direct reports and col-

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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/efmLF](http://ow.ly/efmLF) to learn more.
leagues. I got great reviews—talk about an invitation to rest on my laurels. Because I felt safe doing so (I knew it would not affect my paycheck), on the next round of 360s I expanded my request for feedback to those I knew were not as happy with my leadership. As I predicted my scores went down, but I also learned some things that pushed me to change my approach to meet needs more diverse than my original—and closer—group of reviewers.”

**What have you read this year?** “One of the reasons we started the leadership book study was to help nudge us beyond the last thing we learned to something challenging and new. We know that leading and learning is not a ‘crossed off and done’ task but it can be easy to feel like we’ve studied enough for awhile. Join our leadership book study, or start your own with other leaders in your organization. Read something that doesn’t verify what you already know, but rather pushes you to see something in a new light.”

**Sing with singers who are better than you.** “It can be humbling and motivating to surround ourselves with people who have more talent, knowledge and experience than we do. When I sing with singers better than me, I work harder, I learn from them and I push myself in ways that I don’t when I am in a group where I am one of the best—singing or otherwise. From a lapel button I used to have, ‘Get behind yourself and push!’”

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**

- July 10 - The Power of Three: Time Management, Delegation & SMART Goals
- July 30 - Become A Dynamic Communicator
- August 11 & 12 - Preceptor Training Program (two-day)

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

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