“The fewer the facts, the stronger the opinion.” - Arnold Glasow

RWHC Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – August 1st, 2015

Making Up Your Own Science Costs Lives

From “Measles led to death of Clallam Co. woman; first in US in a dozen years, Tragic outcome for immunocompromised patient shows need for community protection,” a News Release from the Washington State Department of Health, 7/2:

“The death of a Clallam County woman this spring was due to an undetected measles infection that was discovered at autopsy.”

“The woman was most likely exposed to measles at a local medical facility during a recent outbreak in Clallam County. She was there at the same time as a person who later developed a rash and was contagious for measles. The woman had several other health conditions and was on medications that contributed to a suppressed immune system. She didn’t have some of the common symptoms of measles such as a rash, so the infection wasn’t discovered until after her death. The cause of death was pneumonia due to measles.”

“This tragic situation illustrates the importance of immunizing as many people as possible to provide a high level of community protection against measles. People with compromised immune systems often cannot be vaccinated against measles. Even when vaccinated, they may not have a good immune response when exposed to disease; they may be especially vulnerable to disease outbreaks. Public health officials recommend that everyone who is eligible for the measles, mumps, and rubella (MMR) vaccine get vaccinated so they can help protect themselves, their families, and the vulnerable people in their community.”

“Measles is highly contagious even before the rash starts, and is easily spread when an infected person breathes, coughs, or sneezes. If you’re not protected, you can get measles just by walking into a room where someone with the disease has been in the past couple of hours.”

“Children should be vaccinated with two doses of MMR vaccine, with the first dose between 12 and 15 months and the second at four-to-six years. Adults born after 1956 should have at least one measles vaccination; some people need two.”

“The Washington State Department of Health immunization program has Frequently Asked Questions about measles and the measles vaccine written for the general public at http://ow.ly/PfsDD.”

“The measles diagnosis for the Clallam County woman brings the state’s case count to 11, and is the sixth in Clallam County for the year. The last confirmed measles death in the United States was reported in 2003. More information about measles nationwide is available on the Centers for Disease Control and Prevention (CDC) website at www.cdc.gov/measles.”

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RWHC Eye On Health, 7/14/15
Why Not Just One Huge Hospital Per State?

From “They’re Called ‘Critical Access Hospitals’ for a Reason” by John Commins, senior editor at Health-Leaders Media, 3/11/15. While this commentary dates back to March, it does an excellent job capturing the current mood of most rural health leaders:

“They’re called ‘Critical Access Hospitals’ for a reason. These healthcare outposts provide ‘critical access’ to people who live in remote areas.”

“That was the intent of the legislation that created CAHs in 1997 at a time when rural hospitals were shuttering at an alarming rate. Congress understood that rural America needed extra Medicare dollars to keep the doors open at hospitals that serve an older, sicker and poorer patient mix. It’s staggering to think of the challenges that CAHs face:

- Because of their location and size, CAHs have few economies of scale, little leverage with vendors or payers, or a sufficiently large patient mix or volume of commercial payers to help cover costs.
- CAHs are often limited in their ability to provide some of the more lucrative services that are cash cows for larger hospitals in urban areas.
- Recruiting clinicians to rural areas is a slog.

And because of all those challenges, it’s also more difficult to collaborate with other healthcare providers from such an isolated perch. It’s surprising to learn that only 40% of CAHs operate in the red.”

“Unfortunately, some people in Washington, DC, have short institutional memories. For the past couple of years, reports from the Office of the Inspector General at the Department of Health and Human Services have made it clear that they believe the CAH designation and funding scheme should be overhauled.”

“In its latest shot across the bow, OIG this week called for a re-examination of the swing bed program that allows CAHs to provide long-term care. The OIG audit claimed that the federal government has overpaid CAHs $4.1 billion over the past six years for services that could have cost less in relatively nearby skilled nursing and long-term care facilities.”

“Rural healthcare advocates rallied around the reply to the OIG recommendations from former Centers for Medicare & Medicaid Services Administrator Marilyn Tavenner (late 2011 to early 2015), who challenged the OIG findings and recommendations in her formal response, and suggested that auditors don’t understand healthcare delivery in rural areas.”

“While Tavenner’s rebuff of OIG was heartening for rural providers, she no longer runs CMS. Regardless, the Obama budget proposal puts CAHs in the crosshairs, and it’s not clear if Tavenner’s replacement, Acting Administrator Andy Slavitt, understands the special challenges posed by rural healthcare.”

“Tim Putnam, president and CEO of Margaret Mary Community Hospital in Batesville, Indiana, expresses the concerns of many rural providers who feel that there is a disconnection in the federal government when it comes to rural healthcare.”

‘If you grew up in an urban area or trained in an urban area or work in an urban area, it takes effort to understand the specific challenges that exist in a rural community,’ Putnam says. ‘That is one thing where you see a lot of organizations trying to educate legislators and policy makers and groups like HHS about the specific challenges for rural areas.’”

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**Eye On Health** is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members in partnerships to make their communities healthier... generates additional revenue by services to non-Members... ongoing use of strategic alliances in pursuit of its Vision. Tim Size, Editor, 880 Independence Lane, Sauk City, WI 53583

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“The OIG call to re-examine the CAH swing bed program is a great example of that disconnect, Putnam says. It makes sense from a bottom line perspective, but the bottom line doesn’t tell the whole story.”

“You can pick one program and say ‘Aha! It seems like they are paid more than they should be,’ he says. ‘But there are also 99 programs that aren’t paid at all or paid very poorly that hospitals have to run 24/7 that are not reimbursed anywhere near what it costs to provide those services.’”

“Having a swing bed program allows for staffing to exist in these low-volume facilities 24/7,’ Putnam says. ‘The swing bed volume is not very heavy in some communities, but you have [to have the] staff for it because you have to be ready for patients all the time. It helps to have staff available for acute care. A lot of times the hospitals will cross-train staff to work in swing beds and acute care. It really helps form the foundation of having an availability to serve a community need any time day or night.’”

“Putnam says the proposed cuts to CAH funding and a reappraisal of their special status in the Obama budget also send a troubling message at a time when rural hospitals are trying to make the transition from volume to value. ‘Because of sequester and because ‘allowable costs’ eliminate a lot of things that are necessary costs, nobody in the CAH world is making money on Medicare,’ he says.”

“Why should you make money on the government? Well, I can understand that mindset, but really for a hospital to remain viable, they need to make in that 3%–4% range to replace equipment and update facilities and add services. If you are just breaking even you are going to fall behind.’”

“The National Rural Health Association says that more than 40 rural hospitals have closed since 2010. Putnam says most CAHs already lose about 5%–7% on Medicare.”

“If the president’s budget is to reduce 101% of allowable to 100% you will see we will lose 6% to 8%,” Putnam says. ‘We face an income stream that doesn’t allow us to help make a smooth transition to the future. There is no plan you could put forward that says, ‘this is where we will make it.’”

“We should not fault the Obama administration or the OIG too greatly for trying to reduce inefficiencies in healthcare delivery. Any entity that takes taxpayer dollars should be required to account for how they spend it. Too often, however, the cost cuts we’re seeing reflect only the bottom line for a particular service, examined in isolation.”

“Before anyone proposes additional cuts to critical access hospitals, it is not unreasonable to ask that they understand what these hospital do, the challenges they face, and why they were granted ‘critical access’ designation in the first place.”

The State Budget: A Matter of Perspective

A commentary from Jeremy Levin, RWHC Director of Advocacy:

As the State budget season has just recently concluded, it always brings about a post-mortem. The two year budget stands at more than $73 billion and covers dozens of state agencies. However, in this budget a couple of RWHC’s biggest priorities had a combined price tag of just less than $1.5 million, seemingly decimal dust when compared to the hundreds of millions in the cost-to-continue for the State’s Medicaid program or the biennial discussions around K-12 education or cuts to the UW System which run into the hundreds of millions of dollars.
This $1.5 million was tied to the UW System cuts and was the funding for the Wisconsin Rural Physician Residency Assistance Program (WRPRAP) and the Health Care Provider Loan Assistance Program (HPLAP), which were initially eliminated in the Governor’s budget. Two-thirds of the funding came directly from rural hospitals, while the remaining funding originated decades ago through a Department of Commerce account.

More than a dozen healthcare organizations came together to work for a reinstatement of full funding. So why would organizations be interested in training doctors in rural communities? Because they believe, as RWHC does, that rural residency training experiences are a critical tool in recruiting and retaining physicians to rural Wisconsin. A Wisconsin educated and Wisconsin trained physician has a 70% chance of practicing in Wisconsin. Without a Wisconsin residency, that percentage drops by 32 points to 38%. If that same student was born in Wisconsin, the likelihood that a Wisconsin-educated, Wisconsin-trained physician stays in the state is an astounding 86%. (Source: WHA’s 100 Physicians a Year Report)

The Legislative Fiscal Bureau stated that in 2013-14, WRPRAP provided support for 75 rural rotations in family medicine, pediatrics, and psychiatry and provided grants totaling $680,200 for the development of rural residency and fellowship programs. Further, RWHC has received funding from WRPRAP to form the Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME) and has made it possible to grow WCRGME’s initial 8 organizations interested in developing and sustaining rural GME to 28 hospitals, clinics and residency investigating and developing rural GME in only 2 ½ years; and that number is growing.

While $1.5 million may seem like a trivial amount compared to the entirety of the full state budget, these funds are wisely invested and focus on the best ways to train and retain physicians in rural Wisconsin. They are helping to keep local care local and rural communities thriving.

“Investing in Healthy Rural Communities”

RWHC joined the Federal Reserve Bank of Chicago and the UW Population Health Institute and others in sponsoring a one day summit on “Investing in Healthy Rural Communities” on July 1st at the UW Platteville. Below is an update of a pre-conference article from www.TTHONLINE.com (by the Telegraph Herald):

“The goal of the summit was to consider the common interests in resilient, thriving, healthy rural communities that are shared among economic development and community health-focused organizations and how this work can succeed in a rural context.”

“Michael Shuman, director of community portals for Missions Markets and a fellow at Cutting Edge Capital and Post-Carbon Institute, will be the day’s keynote speaker. He is one of the architects of the crowd funding reforms that became the ‘JOBS Act,’ signed into law by President Barack Obama in 2012.”

“The Federal Reserve System and Robert Wood Johnson Foundation created the Healthy Communities Initiative to enrich the debate on how cross-sector and place-based approaches might revitalize neighborhoods and communities while improving health and well being for residents.”

“The Federal Reserve Bank of Chicago collaborated with the University of Wisconsin Population Health Institute, Robert Wood Johnson Foundation, Fort HealthCare, Forward Community Investments, Madison Region Economic Partnership, Rural Wisconsin Health Cooperative, Southwestern Wisconsin Community Action Program and Wisconsin Partnership Program to organize the summit.”

“The event dug into what is working to build health, prosperity and resilience in rural communities. It featured national speakers and local leaders in community and economic development and community health improvement sharing examples of

Broadband in Wisconsin

- In total there are 135 broadband providers in Wisconsin.
- There are 804,000 people in Wisconsin without access to a wired connection capable of 25mbps download speeds.
- There are 954,000 people in Wisconsin that have access to only one wired provider, leaving them no option to switch.
- Another 202,000 people in Wisconsin don’t have any wired internet providers available where they live.

http://broadbandnow.com/Wisconsin
successful community integration between the disciplines from the perspectives of policy, practice and financing.”

The conference sold out early with more than 200 registrants; more individuals participated than any previous such meeting sponsored by the Federal Reserve, including meetings in Minneapolis, New York and Los Angeles.

A “crowdsourcing” exercise at the end of the day identified priorities of the participants regarding their hoped for next steps from the meeting. The top “vote getters” were access to broadband for all rural residents and implementation of Michael Shuman’s model for rural community development to keep local businesses, including rural hospitals, local through local investment and purchasing.

Recordings of the plenary sessions will be available soon through the Federal Reserve & RWHC websites.

“Essays on People, Place and Purpose”

From “Investing in What Works for American Communities: Essays on People, Place and Purpose” by the Federal Reserve Bank of San Francisco and the Low Income Investment Fund, 2012:

“People and Places—At one time, policy discussions revolved around whether community development was about people or places. I would argue that the debate is over and both sides won. Successful community development is based on attention to both the physical infrastructure, whether housing or commercial spaces, and the health and welfare of the residents therein. Safe and affordable housing will always be an important concern for lower-income Americans, but the recent recession and resulting damage to communities across the country make it clear that communities are more than physical structures. Sustainable communities—those that can weather economic downturns—not only provide decent housing, but also have the resources to support individuals and families and to create a dynamic business environment. For this reason, community development today is a multidisciplinary exercise that challenges us to think holistically about how housing relates to jobs, educational opportunities, transportation, health care, and other services and amenities.”

“I envision a time in the near future when our fields and the people who work in them do not need to make a special effort to develop partnerships because we will be working side by side in communities, in states, and nationally, with common aims, combining our best assets and skills to improve the lives of all Americans. In fact, we are likely to look back at this time and wonder why community development and health were ever separate industries.” Risa Lavizzo-Mourey, MD, MBA is president and CEO of the Robert Wood Johnson Foundation, the nation’s largest philanthropic organization dedicated to improving health and health care.”

The essays can be downloaded at no cost from: http://ow.ly/PeWyD

What Works to Improve Rural Health?

Concurrent with the Federal Reserve Bank of Chicago’s multi-sector Investing in Healthy Rural Communities conference on July 1st in Platteville, the University of Wisconsin Population Health Institute further enhanced their “What Works? Strategies to Improve Rural Health.” This new resource “shares key steps toward building healthy communities—rural, urban, and in between—along with many policies and programs that have been tested or implemented in rural areas.” It is available at: http://ow.ly/PeRz6.

“You can also search the main database for policies and programs that have been tested or implemented in
settings like yours, or adopt strategies that have been tested elsewhere but seem like a good ‘fit’ for your community’s priorities, needs, assets, and values.”

“Find a strategy that could work in your community at www.whatworksforhealth.wisc.edu.”

Rural Health Care: “Nimble & Evolving”

Tim Size, RWHC Executive Director, spoke at Wisconsin’s annual Rural Health Conference in June giving an annual “state of the state” address along with the Wisconsin Hospital Association’s President and CEO, Eric Borgerding. This year, his focus was on “Rural Health in Wisconsin: Nimble & Evolving.”

“Wisconsin rural health has its share of challenges, like all communities across the country. But it is good and necessary to pause and celebrate what we are doing well. We need to face our ongoing challenges through the lens of our strength. To quote John McKnight, the grandfather of asset based community assessments, ‘the place to look for care is in the relationships of neighbors and community’—on our good days, the bedrock of rural America.’”

“Five examples of key strengths that were highlighted at the conference:

- Quality of care is strong in rural Wisconsin
- Rural hospitals continuing in a key role
- Health care continues as major driver of rural jobs
- Rural GME Partnerships are growing
- Increasing rural hospital community engagement”

“So as the audience didn’t feel its work was done; the talk ended with a robust advocacy agenda for ongoing improvement:

- Fight Medicare/Medicaid Cuts to core funding
- Create relevant ‘volume to value” incentives
- Assure needed statewide workforce
- Include local providers in insurance networks
- Enhance physician engagement/satisfaction
- Make most effective use of all caregivers
- Support rural economic and community growth
- Avoid rural collateral damage as giants battle”

For the curious, a complete PPT of the talk is available at http://ow.ly/Pu6ry.

A Statewide Focus on Rural Binge Drinking

RWHC is in year two of a Development Grant with the Healthier Wisconsin Partnership Program. “A Collaborative Response to Reduce Binge Drinking in Rural Wisconsin Communities” was launched as a community/academic partnership program with staff from the Medical College of Wisconsin. The two-year pilot program aims to reduce the prevalence of binge drinking in adults through the use of the Alcohol Use Disorders Identification Test (or AUDIT) in primary care and urgent care settings.

During the first year of the grant, academic and community partners recruited four rural Wisconsin community hospitals as pilot sites to implement the screen, established Community Advisory Teams in each local community, trained staff in the implementation of the program, and assisted in the creation of a resource manual available to those patients who screened positive for binge drinking behaviors. Community hospitals participating in the project are: Memorial Medical Center in Ashland, Gundersen Boscobel Hospital & Clinics in Boscobel, Moundview Hospital & Clinics in Friendship, and Stoughton Hospital in Stoughton.
Patient screening started in January of 2015 with each hospital providing the AUDIT screens for a minimum of four hours per week. The patient is given information on the program and asked if they would like to volunteer to participate in the research project by completing a ten-question quiz on their drinking behavior. The patient self reports this information on the quiz, and if they screen positive for binge drinking behavior, they can meet with a local health educator if they would like to learn more about binge drinking or other resources that may be available to them in their community. Data collected during this screening process does not include patient identification and is submitted to the academic partners for tabulation and analysis.

In addition to the AUDIT screens, members of the community advisory teams (CATs) are kept informed on the progress of the pilot project and are also involved in providing feedback to the community and academic partners regarding how the program can make the biggest impact on the local level. CAT members include healthcare professionals, AODA staff, clergy or faith-based individuals, local educators, members of law enforcement, and other local business and civic leaders.

Initial results indicate that the level of binge drinking in the four participating communities is in line with the state averages. In two communities there were lower than average response rates, while the other two had higher than average responses. In all four communities, patients who screened positive did meet with a health educator to receive more information about binge drinking and a list of local resources that are available to them should they want more information or assistance. The project will continue through 2015 and the group is exploring additional funding to expand the grant program to more locations in 2016.

“To be very successful, it is suggested that you develop a ‘pre-occupation with failure’ as noted in ‘Journey to an Effective Safety Culture’ by the Clarity Group, available at: http://ow.ly/Pu4Tz. Not easy for those who get promoted for doing well, A-students, high achievers. Many try to avoid failure, finding it quite uncomfortable, even worse for those who are perfectionists. The statement, ‘It is ok to make mistakes,’ is code for, ‘It is ok for YOU, but not me.’ This can be a deep seated belief system, and it might be time to un-seat it. Failure is a gift. Look back. What have you learned the most from? (Insert a few moments of failure reflection here)’

“In the world: The news headline today, ‘Who do you blame for the economic crisis in Greece?’ reflects a larger culture that wants to find someone to blame for failure. We look to spin a story, make excuses or blame others, tactics hardwired early in life to get us out of the hot seat and avoid disappointing others or getting punished.”

“In our organizations: From the larger culture to our workplace environment, this hardwiring is often evident. If missteps at work reveal a ‘blaming’ culture, start the conversation about changing it to a learning environment. A good resource is (my oft quoted) life philosophy book, The Four Agreements, by Don Miguel Ruiz, where one directly related agreement is, ‘be impeccable with your word.’ Establish an organizational ‘ground rule’ to just tell the truth and then make it safe to do so. Think of leaders who can admit their mistakes and work to make it right. This is authentic, human leadership and those are the people we want to follow.”

“In our teams: It can be frustrating to address a problem with someone who refuses to see their part in that problem. Address ‘He started it,’ with, ‘So what are you doing to keep it going?’ Meet ‘It is her fault,’ with ‘What part do YOU own?’ And keep in mind that many who err are looking for someone who will say, ‘It’s ok,’ or it eventually will be. Hone your leadership muscle by learning to say that to yourself. If you are already programmed to talk to yourself this way, help others to move toward this self-reassurance.”

Leadership Insights: “Epic Fail”

The Leadership Insights series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues are available at www.RWHC.com.
“In ourselves: Do you tend to react to your mistakes by looking for someone to be at fault? The next time you discover a mistake, stop and pay attention to your thought process. Be a scientist of your own thoughts. Learn to recognize when you are starting to blame and decide instead to do an objective review of your own actions. As you speak about the failure, reflect: ‘Am I being impeccable with my word?’ ”

“Find and nurture a friendship with someone who helps you get your perspective back. These friends or mentors can help you to refocus on what you can learn from a failure, to rebalance when you get thrown off. Ask them to call you out on acting defeated or defensive, signs that you are being over or under accountable.”

“Fail on purpose: (Not with a patient though!) Try something you are pretty sure will not work, intending to experience it with a mind open to learning. Do something you know you will succeed at to remind you that some things DO work out. Use this experiment to reinforce that neither success nor failure are permanent conditions.”

“For health care patients who have suffered our failures, their number one response is that they just don’t want it to happen to someone else. Transparency means that we talk about and own what went wrong to prevent its reoccurrence. Be the leader who creates the kind of environment where these conversations can safely happen. A free assessment for further self-awareness on the topic: http://ow.ly/Pu57B”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series go to www.RWHC.com/Services.aspx or contact Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

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