CAHs–Don’t Fix What’s Not Broken

From “Hospitals and Rural Communities Minimum-Distance Requirements Could Harm High-Performing Critical-Access” by Michelle M. Casey, Ira Moscovice, G. Mark Holmes, George H. Pink and Peiyin Hung in *Health Affairs*, 34, no.4 (2015):627-635:

**Summary**–“Since the inception of the Medicare Rural Hospital Flexibility Program in 1997, over 1,300 rural hospitals have converted to critical access hospitals, which entitles them to Medicare cost-based reimbursement instead of reimbursement based on the hospital prospective payment system (PPS). Several changes to eligibility for critical-access status have recently been proposed. Most of the changes focus on mandating that hospitals be located a certain minimum distance from the nearest hospital. Our study found that critical-access hospitals located within fifteen miles of another hospital generally are larger, provide better quality, and are financially stronger compared to critical access hospitals located farther from another hospital. Returning to the PPS would have considerable negative impacts on critical-access hospitals that are located near another hospital. We conclude that establishing a minimum-distance requirement would generate modest cost savings for Medicare but would likely be disruptive to the communities that depend on these hospitals for their health care.”

**Overview**–“In response to concerns about access to care for rural Medicare beneficiaries, the Balanced Budget Act of 1997 established the Medicare Rural Hospital Flexibility Program and criteria for designating institutions as critical-access hospitals. In the years before the creation of the program, rural hospitals experienced widespread financial difficulties and closures. Unlike hospitals in Medicare’s hospital prospective payment system (PPS), whose Medicare reimbursement is based on the average cost of patients in each diagnosis related group or ambulatory payment classification, critical-access hospitals receive cost-based Medicare reimbursement (99 percent of allowable costs for inpatient and outpatient services). According to section 1820 of the Social Security Act of 1965, to be certified as critical-access hospitals, rural hospitals are required to meet eligibility criteria related to their location in a rural area, number of beds, average length-of-stay, and provision of emergency services.”

“Initially, critical-access hospitals were required to be located more than thirty-five miles from the nearest hospital, or more than fifteen miles in areas with mountainous terrain or only secondary roads. From 1997 through December 2005, however, states could waive the distance requirements for hospitals designated by the governor as ‘necessary providers’ of health care services. Beginning in 2006, any new critical-access hospitals must meet the distance requirements, but existing institutions were allowed to remain in the program.”

“Remember, a dead fish can float downstream, but it takes a live one to swim upstream.” - W. C. Fields

RWHC Eye On Health, 4/11/15
“Medicare’s cost-based payments to critical access hospitals (including beneficiary cost sharing) account for only 5 percent of all Medicare inpatient and outpatient payments to hospitals. However, they have generated interest from policymakers who are concerned about deficit reduction and about whether the number of critical-access hospitals has expanded beyond the original legislative intent.”

“The fiscal year 2015 budget submitted to Congress by the Obama administration proposed to ‘prohibit CAH [critical-access hospital] designation for facilities that are less than 10 miles from the nearest hospital.’ If this proposal were implemented, there could be two major effects on critical access hospitals: The number of hospitals with that designation would be reduced, and hospitals that lost critical-access status and ended up in the PPS could experience a substantial reduction in Medicare revenue.”

“Recent studies found that institutions that converted to critical-access hospitals had higher expenses per admission than nonteaching rural hospitals of similar size that did not convert and that critical-access hospitals had higher mortality rates for Medicare patients with certain medical conditions than other acute care hospitals did. Despite their limitations, including methodological issues related to the comparison group used and the treatment of transferred patients, these studies have been widely cited as evidence of the need to reexamine cost-based reimbursement for critical-access hospitals.”

“However, cost-based reimbursement has financially stabilized many critical-access hospitals and allowed them to invest in quality improvement activities, including additional staff and training to improve patient care. It has also allowed critical-access hospitals to invest in upgraded facilities and equipment, which may result in improved diagnosis and patient care. In addition, subsequent studies of mortality rates at critical-access hospitals have found that their surgical mortality rates are equivalent to those at other types of hospitals, and their stroke mortality rates are similar to those at other hospitals with relatively low volumes.”

**Discussion** “This study found that hospitals that could lose critical-access status because of a minimum distance requirement had a higher volume of patients, were more financially stable, were more likely to publicly report quality data, and had better quality performance than critical-access hospitals located farther from other hospitals. These findings have several policy implications.”

“First, using only distance from another hospital to determine whether a hospital is able to retain critical-access certification is a narrow criterion. Clinical expertise, physician distribution, the availability of technology, sufficient volume to maintain key services, the availability of other health care providers, and the needs of special and underserved populations are surely as important as geographic distance in determining which hospitals should receive cost-based reimbursement.”

“Second, loss of critical-access status and cost-based reimbursement could have potentially devastating financial consequences for many critical-access hospitals. These policy proposals are being made at a time when many of the institutions are already facing financial challenges. For example, Medicare bad-debt payments for critical-access hospitals are being reduced from 100 percent to 65 percent, phased in over a three year period beginning in fiscal year 2013.”
“Hospitals may not have sufficient time to respond to reimbursement changes by altering their behavior or strategy, such as by joining accountable care organizations, altering service mix, or aggressively trimming costs. Indeed, after loss of critical-access status, the limited liquidity of many critical-access hospitals could limit their ability to operate long enough to develop and implement potential responses.”

“Third, and most important, these policy proposals do not recognize the potential harmful impacts on the rural health care system and access to care for rural residents. Many rural hospitals could be considered critical safety-net facilities despite their close proximity to nearby hospitals if, for example, they have a high proportion of Medicaid patients. A substantial reduction in financial support could lead to a renewal of the high rural hospital closure rates of the 1990s, with concomitant deleterious effects on the health of these communities. Because hospitals often are a major employer in their community, changes could also lead to a decline in the economy of many rural communities. Finally, if financially vulnerable critical-access hospitals were to close, residents of many areas would experience increased travel time to a different hospital.”

“Collective Impact” Requires Building Trust

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

Rural and urban Wisconsin has long been a hot bed of health care innovation. And it has paid off. When you compare apples to apples, our costs are lower than most states while at the same time the quality of our care is consistently at or near the top.

But we must and can do better. The State of Wisconsin and key private sector partners have received a $2.5 million grant from the Centers for Medicare & Medicaid (CMS) to develop a State Health Innovation Plan (SHIP). The Plan’s goal is to “accelerate multi-stakeholder, collaborative statewide quality improvement and payment reform.” If done well, significant dollars may be available from CMS to facilitate the Plan’s implementation.

SHIP leadership has based this initiative on the idea of “collective impact.” In other words, the work is designed to bring together many freestanding organizations to establish a common vision, adopt a shared set of measurable goals and pursue evidence-based actions that reinforce one another’s work.”

Five administrative building blocks have been identified as essential to the success of this statewide initiative: (1) Common Agenda, (2) Shared Measurement System, (3) Mutually Reinforcing Activities, (4) Continuous Communications, and (5) Backbone Support Organization.

These tasks are essential, but as important, successful statewide change requires relationship and trust building among diverse stakeholders. In a public sector overshadowed by hyper-partisanship and a private sector increasingly dominated by remote and concentrated capital, trust building is at a premium.

About twenty years ago, I had the opportunity to talk about the importance of trust in an article called “Managing Partnerships” published by Health Care Management Review. What follows are a few observations from that article that I believe have stood the test of time.

Collaboration inside a group is the path to greater productivity while competition leads to higher performance when it is among unrelated organizations. The understanding of who shares a common future or dependency clearly becomes a critical issue when trying to develop collaborative relationships.
Above all, collaboration requires the development and maintenance of trust.

Trust is a fragile element among organizations, constantly in need of regeneration as key individuals and circumstances change. Initiatives that require the collaboration of many actors, whether individual or corporate, bog down if they require proof and re-contracting every step along the way. Development of systems of any complexity requires collaboration, and collaboration requires trust.

Trust is in good part dependent on a belief and the experience that we can accomplish more together than separately. This is not new. As Ben Franklin famously quipped at the start of the American Revolution: “We must all hang together or, most assuredly, we shall all hang separately.”

Relationships among multiple organizations certainly approach the complexity to that found within any family. While many families rely on prior agreements regarding individual responsibilities and dispute resolution, this is not what makes a family. It is the commitment to each other and shared goals that transcend rules held by a magnet to the refrigerator door.

Examples of collaborative behaviors to be encouraged:

- SHIP leadership needs to earn the trust of participants and protect that reputation as the critical asset it is, both from real or perceived breaches.
- SHIP participants need to work actively to build trust with each other.
- All participants need to recognize that earning trust takes time and has natural limits to how quickly it can be developed.
- All participants need to recognize that relationships within the SHIP initiative will be more amorphous or messy than relationships built on control of one party over another.
- All participants will need to be responsive to changing conditions and return whenever possible to the spirit rather than the letter of prior agreements.

At its core, health care is about relationships, between caregivers and their patients, partners in the complex art and science of healing and health promotion. Just as trust is fundamental to our relationship with our physician, building and maintaining trust is fundamental for any “collective impact” by those organizations that propose to make Wisconsin healthier and to promote more cost-effective care.

Don’t Eat Our UW Seed Corn

From “Blank’s Slate,” a blog by University of Wisconsin-Madison Chancellor Becky Blank, 4/2/15:

“At UW–Madison, 100 percent of faculty are expected to conduct research, some of it alongside graduate and undergraduate students, and they spend an average of 21.3 hours per week on research activities. This research is essential to our state economy, bringing in approximately $800 million in outside investment to the state of Wisconsin. UW–Madison’s $1.1 billion in total research expenditures was the fourth highest among all universities nationwide in 2013.”

“The state funded portion of the faculty payroll in 2013-14 was $186 million. At the same time, expenditures from external sources (including funds raised by faculty in competition for grant funds) was $643 million. That means for each dollar in state-funded salary, UW-Madison faculty bring in $3.50 in funding to support their research.”

“Many faculty members use their research dollars to employ others—undergraduates, graduate students, post-docs, research staff, and administrators who oversee their operations. This is particularly true for faculty who run labs that require multiple people to operate. It’s not inappropriate to think about these faculty as small business owners. They have to continuously raise the money to keep their staff employed.”

“If they choose to leave the university in response to an outside offer, we lose not only the substantive scientific contributions that they are making, but we lose support for our students and staff lose their jobs.”
Rural Losing Graduate Medical Education?

Proposed cuts to rural Graduate Medical Education (GME) were contained in the biennial budget when the Wisconsin Rural Physician Residency Assistance Program (WRPRAP) was deleted as part of the shift to a UW authority model. While advocates believe this deletion was inadvertent, many in the medical education community have contacted state legislators to reinstate the funding and restore the program.

Grant funding from WRPRAP funds the Wisconsin Collaborative for Rural Graduate Medical Education (WCRGME), formed in early 2012 with a mission to address the rural shortage of primary care physicians through the expansion of rural GME.

Kara Traxler, RWHC Director of Rural GME Development & Support, and Jeremy Levin, RWHC Director of Advocacy, were recently in Reedsburg to testify at the last public hearing before the Joint Finance Committee (JFC). After about four hours of waiting they were able to pack-in a lot of history and success about the WRPRAP program into the two minutes allowed.

Eye on Health interviewed Kara with the questions she could have answered at the public hearing.

EOH: What is your role in rural GME development? As Director of Rural GME Development, I provide leadership and technical assistance to sites interested in developing rural GME. 

Since evidence shows that physician residents that train in rural areas are 2-3 times more likely to practice in rural areas, WCRGME is helping rural communities “grow their own” doctors—our vision being to train rural doctors for rural people. There are many ways for organizations to be involved in rural GME including rotations, Rural Training Tracks (RTTs), fellowships, and urban residencies with rural/community tracks. While we originally focused on family medicine, we have since expanded to other specialties including a general surgery and psychiatric rural/community track with an OB/Gyn track under development. Ultimately, I see myself as a facilitator, relationship builder, coach, and cheerleader in a complicated but necessary process to ensure that there is quality access to healthcare in rural Wisconsin where about a 20% of our population resides, but less than 10% of physicians practice.

EOH: What are rural physicians’ concerns about helping to train young physicians? They have limited resources and a lot of demands on their time already, so we answer many questions about how training residents would affect their overall practice and day-to-day schedules. There’s a need to give them practical answers as to what having a resident in their practice would look like for them. Faculty development is expressed as a need statewide. That’s why WCRGME started a Rural Medical Educators Faculty Development Conference every fall which offers faculty development that caters to the unique needs of rural faculty and preceptors. It has been helpful for physicians to know what help is available when they are involved in teaching—from university and academic resources, to staff and administration at their own organizations, to the WCRGME’s staff and membership who stand ready to assist and answer questions—there are a lot of resources available.

EOH: What has been the history of rural GME in Wisconsin? The short answer is that there were 6 RTTs in the 90s. The Baraboo RTT is currently the only one of those programs that remains. My understanding is that those closings were due to a combination of funding challenges and a downturn in family medicine interest. Since that time, the interest in family medicine has risen and the number of medical schools and medical schools’ class sizes has increased. In Wisconsin in particular, we’ve seen the addition of the Wisconsin Academy for Rural Medicine (WARM) and the expansion of the Medical College of Wisconsin (MCW) into northern Wisconsin. During this time we have seen very little growth in GME slots. If we don’t develop additional residency opportunities in Wisconsin, especially in rural, we will be exporting students to other states for this training, where there is a high likelihood that they will stay to practice.

EOH: How have WRPRAP and WCRGME helped with rural physician shortages in Wisconsin? There are now two additional rural residency slots with the opening of the Monroe Clinic Family Medicine Residency Program starting its first residents July 1. The Aurora Family Medicine Program is developing an
RTT in the Elkhorn area. Also, along with Wisconsin Council for Medical Education and Workforce (WCMEW) and the Wisconsin Department of Health Services (DHS), we are working in the northwest part of the state to collaborate with multiple healthcare and academic organizations on growing GME in that physician shortage area. In addition, the expansion of rural rotation sites among WCRGME’s members from 8 before the formation of WCRGME in 2012, to 28 as of late last year has more residents receiving more training at rural locations. We have just started, but we have a lot more yet to accomplish.

EOH: What would be the impact on rural healthcare if the deletion of WRPRAP is not removed from the state budget? Without the availability of these funds, I believe most rural hospitals would not have the resources to fully investigate and develop rural GME at their organizations. With the residency development costs running around a half million dollars, the financial barrier is just too great. Even potential rural rotation sites, with a much lower development price tag, would still struggle to pay for the administrative and physician time to get started. With the removal of WRPRAP from the state budget, the WCRGME program and thus the leadership and technical assistance it provides would be in jeopardy.

EOH: What is your vision for the WRPRAP and WCRGME programs and the larger rural GME training in Wisconsin? My vision is for Wisconsin to continue to collaborate and grow its opportunities for rural physician training. Our state is already recognized nationally as an innovator in this area. It is imperative that the WRPRAP and WCRGME programs continue so that WARM students and new MCW Green Bay and Central Wisconsin Campus students, many of whom have expressed a strong desire to practice in rural communities, have more rural residency slots available to them. Expanding the number of rural slots and rotations sites gives us the ability to train the rural physician workforce critical to meeting the healthcare needs of our entire state.

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**Leadership Insights: “Independent Cusses”**

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

“For as much as I write and teach others about the importance of team building and working collaboratively, two truths are: ‘being a team player does not come naturally to me.’ And ‘I keep working at it, and it is not easy.’”

**Innate personality traits explain a lot.** “Some of us were just born with an independent streak, taking ideas to action with a single mindedness that works (when it works!), and others are born with a predisposition to add a step between ‘ideas’ and ‘action.’”

“That step is: involve others and look at things from a group perspective. In healthcare there is little that is done alone because all the parts are interconnected for the benefit of the patient and you ‘team tenders’ are critical to keeping this on track. No matter what our personality preferences are, they don’t get us off the hook for meeting a very high standard of working together effectively.”

**Team tenders, speak up.**

“When we have left you out of planning, information loops, decisions, etc., let us know. It helps when you approach us assuming good intent because most of the time that is absolutely the case. We just don’t think like you do, and we need your perspective.”

**Independent cusses, develop a habit of checking-in with key people.** “Ask, ‘How am I doing at keeping you informed?’ Give a brief rundown of progress on projects you are working on that they are not directly involved with. Share the what, why and how of your project. Ask, ‘Can you think of anything in your work/goals that intersects with what I am doing that needs to be considered?’ To take this to the next level:

- **Do a stakeholder analysis.** Project management tools help to prevent miscommunication by taking the time on the front end of projects to identify the people who have a key stake in the outcome or impact of your project. You are probably already thinking about the obvious stakeholders, it’s the less obvious ones that can be missed.

  Sit down with your more systems-thinking colleagues and brainstorm who might be directly and indirectly impacted by your work throughout all the phases of your project.

- **Before hitting ‘send,’ ‘consider’ reply all.** An independent cuss will cuss when someone has ‘replied all’ when in their mind there is no need. In turn, team tenders will feel left out and undervalued when a literal or figurative ‘reply all’ has not happened.

  Ask yourself daily, ‘Who else might want to know about this, or might construe not being included as a slight?’

- **Listen to how much you think or say ‘I’ instead of ‘we.’** You may not change a thing, but just pay attention for what it might reveal about your connection to your team in the way you work. At the same time...

- **Appreciate your ‘I’**. Not everything is done by a team. Individual contributions are important. There is no one right way to get the work done, and we do our best when we bring our natural talents to bear. The trick is remembering that any trait over used can become a problem.
- At least occasionally offer to help out with team efforts where you would not normally involve yourself. For example, if you don’t like or see the need for work parties, go anyway and help with the clean up.

- Do a personality inventory with your team. There are many available and all team members can benefit from the insight to themselves and each other to learn to appreciate different gifts each team member brings. They are a fun way to explore where we are challenged and how not to take these differences personally since they provide an objective platform for our communication about those differences.

- Address your leadership challenges with personalized skill development.

- Explore tips and tools to help you become a more effective communicator.

For more information on individual or group coaching sessions, email Jo Anne Preston at jpreston@rwhc.com or Cella Janisch-Hartline at chartline@rwhc.com or call either at 608-643-2343.

*Have you considered seeking individual professional coaching from RWHC for your leadership development?* A best practice of successful leaders is to:

- Maximize your gifts—understand your personality traits that drive your work and leadership style.

- Address your leadership challenges with personalized skill development.

- Explore tips and tools to help you become a more effective communicator.

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