Rural Hospital & Medicare’s Common Ground

By Tim Size, RWHC Executive Director:

Early last year, recognizing the longstanding tension on multiple issues between rural hospitals and the Centers for Medicare and Medicaid Services (CMS), Representatives Ron Kind (D-WI) and Reid Ribble (R-WI) requested then United States Department of Health and Human Services Secretary Kathleen Sebelius direct CMS to implement a face to face conversation with rural hospitals in Wisconsin.

Last August, a “delegation” from the Wisconsin Hospital Association (WHA) and the Rural Wisconsin Health Cooperative (RWHC) had the opportunity to meet in Washington with Sean Cavanaugh, CMS Deputy Administrator & Director Center for Medicare along with some members of his senior team.

Rural CEOs shared examples of what they experience as an ongoing “under-appreciation” by CMS regarding the challenges they face providing local health care to Medicare beneficiaries. Mr. Cavanaugh and his team listened thoughtfully and shared their perspectives. All agreed that Medicare beneficiaries would be better served if rural providers and CMS could find a way to see each other less as adversaries and more as partners with common goals.

To that end, Mr. Cavanaugh accepted an invitation to come to Wisconsin for an “on the ground look” at rural hospitals. Our intent was to make more “real” the essential nature of hospitals and clinics in rural communities. Wisconsin has many examples of rural hospitals, found across America, that are committed to the healthcare “value” movement—pursuing high quality, cost-efficient community-based care—a goal we share with CMS and the Medicare beneficiaries we both serve.

Given our state’s tradition of collaboration and strong rankings for both Medicare quality and cost, we believe rural Wisconsin has much to offer CMS as it considers policies aimed at the ongoing evolution of American healthcare, in particular for critical access and rural prospective payment system hospitals.

Earlier this month, on a perfect mid-summer day, the conversation continued in the rural southwest Wisconsin communities of Monroe and Lancaster.
Representatives from CMS included: Sean Cavanaugh; Nanette Foster Reilly, Consortium Administrator for Financial Management & Fee-for-Service Operations; and Gregory Dill, Associate Regional Administrator, Division of Financial Management and Fee-for-Service Operations, Region V–Chicago Regional Office.

WHA and RWHC were joined by a cross section of rural hospital leaders, representatives from both of the state’s medical schools and the Wisconsin Council on Medical Education and Workforce.

At the Monroe Clinic during the morning, our guests heard several great presentations regarding Wisconsin’s “grow your own” partnerships working to educate and train the next generation of physicians for rural Wisconsin. Monroe Clinic, with a five star rating on Medicare’s Hospital Compare website, is in the top 7% of the country’s hospitals and has no trouble attracting residents and fellows into its growing Graduate Medical Education (GME) programs.

Wisconsin is clearly not waiting for Washington to act. But we also took the opportunity to indicate how we are constrained by Medicare’s outdated system for funding GME—a system that favors long-established programs in the urban northeast section of the US at the expense of the need for rural and primary care physicians across the country.

The afternoon visit at Grant Regional Health Center (GRHC) in Lancaster focused on the high quality of care offered in rural and urban hospitals throughout the State. GRHC is a critical access hospital rightly proud to be the smallest healthcare client the Disney Institute has ever worked with and that has become a customer service model of excellence for facilities across the country, regardless of size.

At both sites, the case was made for the collaboration, transparency and rural relevance that distinguish our rural hospitals—strong rural models are readily accessible in Wisconsin and across the country.

We took the opportunity to request that CMS give careful attention to a report that the National Quality Forum (NQF) will soon be submitting to CMS, requested as part of CMS’s annual contract with NQF. The report gives a series of recommendations from a Committee convened for the first time ever to address “performance measurement issues for rural small-practice and low-volume providers.” Without such measures, rural America will be left behind as CMS and insurers move into a new age of transparency and accountability.

The NQF Report suggests how “to mitigate challenges in payment incentive programs; identify which measures are most appropriate; and recommend how future development resources are best directed to address particular measurement gaps areas.”

Not speaking for the Committee, but as an active member, I expressed a deep concern that CMS will not give the recommendations the full review they deserve due to their already full plate—that once again rural health will get the short end of the stick.

Mr. Cavanaugh and his team fully engaged with us and they clearly appreciated the relevance of the “Wisconsin Story” to rural health nationally—that collaboration matters and that the more transparent we are, the more we engage in improvement.

24th Annual $2,500 Monato Essay Prize
A $2,500 Prize for the Best Rural Health Paper by a University of Wisconsin student or recent graduate. Write on a rural health topic for a class and submit by June 1st.
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Nicole Clapp, President/CEO, Grant Regional Health Center, shares the story of America’s small rural hospitals.
States Grow GME as Congress Fiddles

From the blog “A State-Based Strategy for Expanding Primary Care Residency” by Arthur Kaufman and Charlie Alfero at www.healthaffairs.org, 7/31/15:

“As we look to improve overall health and reduce unnecessary spending, primary care physicians become increasingly critical. However, there aren’t enough primary care physicians to meet this need—especially in rural or poor urban areas. Current estimates predict that by 2035, our country will face a shortage of more than 44,000 primary care physicians.”

“Like many other states, New Mexico is already experiencing this shortage. In 2014, the state had 96 primary care shortage areas, including areas in 32 of 33 counties in the state. At least 220 new physicians are needed to meet the current demand for basic medical care. The state has responded with an innovative and cooperative effort that led to legislation that is already expanding access to care for our neediest residents.”

“While new medical schools are opening and established schools are increasing enrollment across the nation, there’s a residency bottleneck in the physician pipeline in many states, especially in primary care. Most of the funding for the country’s 100,000 residency slots comes from the federal government as part of Medicare spending.”

“However, the 1997 Balanced Budget Act placed a cap on such graduate medical education (GME) spending, effectively freezing it at 1997 levels and often locking in the ratio of primary care to specialty residency positions found at many academic teaching hospitals. Despite the ACA’s recognition of the importance of primary care, that emphasis has not been reflected in growth in primary care residency positions nationwide.”

“Within the present payment system, specialty care is more lucrative than primary care, and hospitals may depend on residents, rather than attending physicians, to deliver specialty services in order to recapture financial losses in other areas. Most residencies are based at tertiary care medical centers, which are dominated by subspecialty services and offer fewer opportunities for training in primary care.”

“The specialty-to-primary care ratio often more closely reflects teaching hospital service needs than of overall health workforce needs. To remedy current primary care shortages and avoid future shortfalls, the country needs to add another 1,700 to 3,000 primary care residency slots.”

“Although federal legislation has been drafted to better align GME with state and national workforce needs, the proposed legislation has not made it through Congress. Nor has there been a sufficient, voluntary movement by academic medical centers to align publicly financed GME with the health goals of the nation.”

“Solutions are within reach: for example, a 2014 Institute of Medicine report outlines a mechanism for reforming GME payment while expanding public accountability for GME funding. However, policymakers and academic health center leaders have yet to act. Meanwhile, the nation is experiencing a well-documented, publicized, and significant worsening of its primary care clinician shortages.”

“With continuing legislative gridlock in the federal government, innovations in health services and in health workforce development are emerging from states. There, local solutions can grow from local needs and are often more appealing to state legislators who may be wary of federal policy.”

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

www.RWHC.com  Email office@RWHC.com with subscribe on the subject line for a free e-subscription.
Population Health is Community Health

From the blog “What Are We Talking About When We Talk About Population Health?” by David Kindig, at www.healthaffairs.org, 4/6/15

“The term population health is much more widely used now than in 2003 when Greg Stoddart and I proposed this definition: ‘the health outcomes of a group of individuals, including the distribution of such outcomes within the group.’ The term is often seen in policy discussion, research, and in the names of new academic departments and institutes.”

“The term’s growing use has resulted in a conflicting understanding of the term today. In this post, I discuss the evolution of the term population health, and argue that going forward multiple definitions are needed. While the traditional population health definition can be reserved for geographic populations, new terms such as population health management or population medicine are useful to describe activities limited to clinical populations and a narrower set of health outcome determinants.”

The most influential contemporary contribution to how we understand population health is ‘Why Are Some People Healthy and Others Not? The Determinants of Health of Populations’, a 1994 book by Evans, Barer, and Marmor. No definition of the term appears there, although the concept is described as, ‘the common focus on trying to understand the determinants of health of populations.’ ”

“In my 1997 book, ‘Purchasing Population Health: Paying for Results,’ I proposed the definition as, ‘the aggregate health outcome of health-adjusted life expectancy (quantity and quality) of a group of individuals, in an economic framework that balances the relative marginal returns from the multiple determinants of health.’ This definition included specific measure of population health (health-adjusted life expectancy) as well as consideration of the relative cost-effectiveness of resource allocation to multiple determinants.”

“This definition emphasized that there are investment tradeoffs, which required ‘an economic framework that balances the relative marginal returns from the multiple determinants of health.’ While less appreciated as a hallmark of population health thinking, the economic tradeoffs are equally important. If resources were unlimited we wouldn’t have to make investment choices, but they are limited. A critical component of population health policy has to be how the most health return can be produced from the next dollar invested, such as expanding insurance coverage or reducing smoking rates or increasing early childhood education.”

“In our 2003 article, Stoddart and I simplified the definition to focus on general health outcomes. At the time, the term typically referred to local geographic populations and had not yet been applied to the realm of medical care.”

“Defining population health in terms of clinical populations draws attention away from the critical role that non-clinical factors such as education and economic development play in producing health.”

“Improving total population health requires partners across many sectors—including public health, health care organizations, community organizations, and businesses—to integrate investments and policies across all determinants.”

“Semantics like this can seem arcane, but they also ensure that we clearly understand each other. For the next decade we need to be clear about these two ways of thinking about population health, how they interact, and the important work going on in both of them.”
Foundations That “Get” Rural Health

From the blog “Taking on the Inequities of Rural Life” by Ned Calonge, under “Grantwatch” at www.healthaffairs.com, 7/30/15:

“Is rural living good for your health? If you’re one of a quarter billion Americans who live in metro areas, you may be conjuring up an idyll of burbling streams and fresh air.”

“But rural Americans are more likely than city dwellers to live in poverty. Rural poverty rates are especially high among ethnic minorities and children, according to an analysis of Census Bureau data by the US Department of Agriculture.”

“People living in rural counties frequently have poor access to physicians and behavioral health providers, are more likely to smoke and abuse alcohol, and are at higher risk of suicide and of dying in car accidents.”

“Denise Gonzales, program director at Con Alma Health Foundation, which funds across New Mexico, and Susan Wilger, director of programs at the National Center for Frontier Communities (NCFC), know these statistics well. Gonzales and Wilger spoke to Colorado nonprofit leaders and health policy advocates.”

“Con Alma, under the guidance of Executive Director Dolores Roybal, has been a national leader among grantmakers working to advance health equity in rural areas. Collaboration with rural communities is one way for grantmakers to begin to address rural health disparities, said Gonzales. ‘We have projects that come from the communities, and we empower them to make decisions,’ she said.”

“Part of the NCFC’s work has been to advocate for better access to vital services for people living in rural and frontier communities, where long distances and lengthy travel times are a barrier to good health.”

“One of the ironies of rural life, Wilger noted, is that areas that bear the burden of food production frequently aren’t reaping the benefits. The same workers who bring food to the tables of city dwellers are themselves earning too little to eat nutritious food. Wilger said there is a persistently high reliance on food pantries and federal food assistance in some of the communities where the NCFC works.”

“Just as it’s useful for grantmakers and nonprofits to work closely with rural communities, Wilger believes it’s important for those communities to collaborate among themselves. Both Con Alma and the NCFC share a focus on bringing together local leaders, nonprofits, and government agencies that work in rural areas. When working with such small populations, duplication of efforts can be especially wasteful.”

“Rural counties are aging. In Colorado, people living in rural counties are already older on average than those in urban areas, with a growing number who are over the age of sixty-five, according to the Colorado Rural Health Center.”

“But for now, the best efforts to address rural health inequities, as identified by Gonzales and Wilger, remain the same no matter what the age group: invest in communities, advocate for systemic change, and, of course, work together.”

RWHC Eye On Health, 8/11/15

RWHC Seeks Director of Finance
This senior position is responsible for a variety of activities that enhance the financial health of RWHC members, RWHC and related entities.

http://www.rwhc.com/Careers/JobsatRWHC.aspx
RWHC Focus on Rural Stroke Care

From a Press Release, “Wisconsin Coverdell Stroke Program receives $3.75 million to enhance statewide stroke care,” Wisconsin Department of Health Services, 7/24:

“The Department of Health Services will strengthen coordinated stroke care systems statewide thanks to a 5-year, $3.75 million CDC grant to continue the Wisconsin Coverdell Stroke Program, health officials announced today. Wisconsin is one of only nine states to receive the funding.”

“Continued support for our stroke care initiative will help us increase the likelihood that patients throughout the state receive fast and high quality stroke care,” said Dr. Timothy Corden, Chief Medical Officer, Bureau of Community Health Promotion.”

“Ongoing program partners include MetaStar, the Wisconsin Stroke Coalition, the American Heart Association/American Stroke Association, Rural Wisconsin Health Cooperative, Wisconsin Hospital Association, Wisconsin Office of Rural Health at UW-Madison, the Wisconsin EMS Association, Wellbe, Inc., and UW-Milwaukee’s Center for Urban Initiatives and Research.”

“In the event of a stroke, outcomes often depend on how quickly a patient gets care after symptoms start. Reducing the time before a stroke patient gets clot-busting drugs makes a difference for patients and their families. Working with 29 certified stroke centers and 83 EMS agencies, the state’s stroke program reduced the average time it took to get a patient into treatment by 20 minutes. The renewed grant funds will continue to support timely treatment initiation, and also focus on improving people’s lives after a stroke has occurred.”

Aligned with the Wisconsin Coverdell Stroke Program, and as an active participant in the Wisconsin Stroke Coalition, RWHC has initiated a Stroke Systems of Care Task Force, which will begin this September. This task force will assist hospitals in improving care processes for stroke patients, and covers each of the domains required to achieve the Acute Stroke Ready Hospital (ASRH) criteria. RWHC is partnering with leaders from the Wisconsin Stroke Coalition and the Wisconsin Coverdell Stroke Program to bring participants expert presentations, networking, and best-practice sharing. Partial funding for the Task Force is made possible by the Paul Coverdell National Acute Stroke Prevention program at the Center for Disease Control and Prevention.”

The Friendship Dividend: a Healthier Life

From “Good Friends Are Good for You: They might get on your nerves at times, but good friends have bigger benefits than you may realize” by Tom Valeo and for www.WebMD.com, downloaded 8/5/15:

‘You got to have friends to make that day last long,’ sings Bette Midler. But good friends may help your life last longer, too, according to an Australian study. Conducted by the Centre for Ageing Studies at Flinders University, the study followed nearly 1,500 older people for 10 years. It found that those who had a large network of friends outlived those with the fewest friends by 22%.”

“Why is this so? The authors suspect that good friends discourage unhealthy behaviors such as smoking and heavy drinking. And the companionship provided by friends may ward off depression, boost self-esteem, and provide support. Friends help you face adverse events. They provide material aid, emotional support, and information that helps you deal with the stressors.”

“Close relationships with children and relatives, in contrast, had almost no effect on longevity. Lynne C. Giles, one of the four researchers who conducted the study, emphasized that family ties are important; they just seem to have little effect on survival.”

The Health Benefits of Good Friends—“Lots of research has shown the health benefits of social support. One such study, reported in the journal Cancer, followed 61 women with advanced ovarian cancer. Those with ample social support had much lower levels of a protein linked to more aggressive types of cancer.
Lower levels of the protein, known as interleukin 6, or IL-6, also boosted the effectiveness of chemotherapy. Women with weak social support had levels of IL-6 that were 70% higher in general, and two-and-a-half times higher in the area around the tumor.”

“In 1989, David Spiegel, MD, a professor of psychiatry at Stanford University, published a landmark paper in Lancet. It showed that women with breast cancer who participated in a support group lived twice as long as those who didn’t. They also had much less pain.”

“Sheldon Cohen, PhD, a psychology professor at Carnegie Mellon University, in Pittsburgh, has shown that strong social support helps people cope with stress. ‘Friends help you face adverse events,’ Cohen tells WebMD. ‘They provide material aid, emotional support, and information that helps you deal with the stressors. There may be broader effects as well. Friends encourage you to take better care of yourself. And people with wider social networks are higher in self-esteem, and they feel they have more control over their lives.’ ”

“Other studies have shown that people with fewer friends tend to die sooner after having a heart attack than people with a strong social network. Having lots of friends may even reduce your chances of catching a cold. That’s true even though you’re probably exposed to more viruses if you spend a lot of time with others.”

“People with social support have fewer cardiovascular problems and immune problems, and lower levels of cortisol—a stress hormone,” says Tasha R. Howe, PhD, associate professor of psychology at Humboldt State University. ‘Why? The evolutionary argument maintains that humans are social animals, and we have evolved to be in groups. We have always needed others for our survival. It’s in our genes. Therefore, people with social connections feel more relaxed and at peace, which is related to better health.’ ”

“One thing research shows is that as one’s social network gets smaller, one’s risk for mortality increases,” Holt-Lunstad says. ‘And it’s a strong correlation—almost as strong as the correlation between smoking and mortality.’ ”

The Leadership Insights series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues are available at www.RWHC.com.

“‘Weird, but aptly coined, term for what happens when we get a song stuck in our head and can’t get it out. Why not use the way our brain naturally works in this way to our own benefit? When the day to day fires start to blaze, it helps to have a structure to keep what is important on top of the pile. Build a groove in your brain for reminders about what matters most. Word association seems almost too simple to be useful, but that’s part of the beauty. Think of it as a trigger for keeping priorities straight. Consider the following “brain worms” (or come up with your own!) to set up a focused work week.”

Margin Monday—“Strategic thinking is a leadership competency, and back to back meetings and obligated appointments do not allow for that kind of contemplation. Margin is the concept of actually scheduling time into your calendar to DO this strategic thinking. Set aside time to plan, think, prepare and organize your work intentionally because no one else is going to do this for you. Propose a policy of no-meeting-Mondays, or at least not in the mornings. Use the day to identify priorities for your week, check in with your team on their current goals, asking what support they need from you. An alternative: Metric Monday. What is the data you need to be looking at weekly to make sure that your department is on track? Even if numbers are not your strong suit, it doesn’t get you off the hook. Identify 1-3 key data points (productivity, patient/customer satisfaction, overtime, expenses, etc.) that you will check every Monday.”

Trouble Tuesday—“I heard a speaker say recently to leaders, “Don’t run from trouble, run to it.” Is there something you have been putting off because you have concerns or don’t feel confident about how to tackle it? A difficult conversation you need to have? A can of worms that just really needs to be opened? Make Tuesday the day to look trouble in the eye and face unpleasant challenges.”
Wellness Wednesday—“Has half the week gone by and you find you haven’t built in any time for your own health? Have you skipped lunch, taken no breaks, been holding your breath due to stress? Put time in your Wednesday schedule for your own wellness and be a role model for taking care of your health. An alternative: Why Wednesday – This replaces the old favorite, “hump day” with a reminder that explaining the “why” behind our work increases engagement in the people we need to help us get it done.

Thank you Thursday—“Who do you need to thank? Do you appreciate people in your head but neglect to say it? Who is going the extra mile? Who has come up with a new idea or solved a problem this week? Thanking people for specific effort reinforces desired behaviors. If there has been a past performance problem and it has been turned around, notice it. Give some attention to your high performers as well, especially if you want to keep them. (Aspirus Langlade does this and shared the idea with me, THANKS!)

Fun Friday—“We might not need to be reminded about TGIF, but what do you think about fun at work? Health care is serious, but we need not always be solemn. When we are laughing, we are learning. A sense of humor is a life saver when we have heavy workloads and the pressure is on. What tone do you set by your own body language and facial expression that either gives-or takes away-the permission to have a little fun? Look in the mirror. Be intentional about the messages you exude and generate some lightness in your work environment.”

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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