Rural Must Not Become Collateral Damage

This Commentary, “What Rural Health’s ‘Early Days’ Tell Us About Today” by RWHC Executive Director Tim Size was shared last month with RWHC Members and in various forms was subsequently presented twice in Washington, DC as well as being published by the LaCrosse Tribune and the Daily Yonder.

“I have had the honor to work in rural health for almost 40 years—at the Rural Wisconsin Health Cooperative in Sauk City as well as with the National Rural Health Association and the U.S. Department of Health and Human Services. I appreciate the opportunity to share my perspective about today’s threat to rural health given my experience as part of the rural health movement in the ‘early days’—the 1980s and ‘90s.”

“A new study from the Federal Centers for Disease Control (CDC) shows that Americans living in rural communities are more likely to die prematurely from the top five causes of death (heart disease, accidents, stroke, cancer, and respiratory disease), than are their urban counterparts. This is not the time to be defunding rural health care—particularly given that Medicare’s per capita expenditure for rural beneficiaries has historically been well below that for urban beneficiaries.”

“At the same time, as rural and urban mortality rates have been diverging, 80 rural hospitals have closed over the last few years. In addition, according to iVantage, nearly 700 rural hospitals are vulnerable and could close, representing over one-third of rural hospitals in the U.S. If we don’t act now, we will see a massive round of rural hospital and clinic closures.”

“Closure doesn’t just mean that the CEO needs to find a new job but that the community loses one of its largest employers—an economic engine for local jobs that also supports the recruitment and retention of local businesses/industries.”

“Compared to the 1980s, some policy details are different but the challenge is the same—the need for strong, vigilant rural advocacy to inform and protect against wholesale changes in Medicare, Medicaid and commercial insurance that gloss over their impact on rural health care and communities.”

“The challenges in the 1980s were similar but the advocacy resources are much stronger today; we must make the best use of them:

- The biggest similarity between then and now is that Medicare had then just implemented an entirely new way of paying providers—the Prospective Payment System (PPS) that ‘threw the rural baby out with the reform bathwater.’ Today, a shift to premium support, block grants or reducing state oversight of insurance companies,

“Hope is a state of mind, not of the world. Hope is an ability to work for something because it is good.” Vaclav Havel

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unless the rural context is fully taken into account, would be at least as devastating.

- Initially, rural health advocates had almost no presence in Washington. The National Rural Health Association was just getting organized, there wasn’t a Federal Office of Rural Health Policy and there were very few state offices of rural health.

- We didn’t have the rural Critical Access Hospital (CAH) designation until 1997. Much of the 1980s and 1990s was spent trying to adapt the PPS to the rural context. Contrary to current mythology, CAHs were not developed as a federal charity but the results of a long search to develop a rural alternative to PPS that never worked for small rural hospitals.

- There was only a small and fragmented rural research community who were just beginning to gather the data and do the analysis needed for us to understand our work and how we might think differently about it.

- Very relevant to a far-flung network of advocates, we didn’t have email and the internet to bring us together across significant distances so the exchange of experience and ideas was a lot slower.

- On the positive side, health insurance plans had fewer closed networks to steer patients out of rural communities; I will come back to that reality as a central threat to our future.”

“We are well placed to not repeat our history, but only if we make sure Washington pays attention.”

“Overwhelmingly, it was the implementation of Medicare’s PPS that created the rural hospital closure crisis in the 1980s.”

“On the first of October, 1983, Medicare implemented a payment model for most hospitals that was tested only in several large teaching hospitals in New England—they didn’t do a trial run in small rural settings or to the best of my knowledge, think very deeply about the impact on smaller, rural hospitals.”

“Through the 1980s, with the unexpected closure of hundreds of rural hospitals, a broad acceptance all too slowly developed that the design of PPS was totally urban centric and negatively impacted rural hospitals in ways that made neither professional nor political sense.”

“We have learned nothing from our past if we allow this to happen to us once again. For the communities who lost a local hospital, it was very personal. It meant a loss of jobs, a blow to pride in their local community, less ability to attract new job creating businesses and above all, a loss to a closer source of care during a medical emergency.”

“For the rest of us it created a feeling of being attacked by our own government and reinforced the stereotype that rural wasn’t very important—that we didn’t need rural hospitals.”

“There was a very strong sense of anger, not all that different than that seen in the 2016 election cycle driving Trump and Sanders’ supporters.”

“Today, NRHA is a national association with more than 20,000 members. It was started by a handful of activists that merged three smaller associations, one each for community health centers, researchers and rural hospitals.”

“NRHA’s roots has always been a ‘big tent’—a diverse community of individuals and organizations with one overriding common interest: the health of rural communities.”
In times of crisis or threat, like today, those of us working for rural health have always stood together and had each other’s backs.”

“We need to fight for values that support keeping local care local; in policy talk that means we need Network Adequacy Values that reflect the context of rural insurance markets. The Network Adequacy Council at the Wisconsin Hospital Association has developed these standards to guide our work:

**Accessibility**—Consumers must have access that reflects ‘historical patterns of care’ and/or improved practices and standards of care in their community.

**Transparency and Consumer Engagement**—Consumers must have the ability to determine which providers are in the network and which providers are accepting new patients.

**Choice**—Consumers must have access to a choice of insurers and providers.

**Affordability and Cost Effectiveness**—Network adequacy standards must not result in unaffordable health insurance costs.”

“In Wisconsin and nationally, we have already seen what happens when these values are neglected:

- Health plan doesn’t offer contract to local hospital.
- Health plan offers a contract at only Medicaid rates or admits that they don’t want a contract.
- Health plan contracts with hospital, but doesn’t contract or credential employed physicians.
- Hospital has a contract with health plan, but no one is allowed to be referred to the hospital.
- Health plan contracts only with the clinic, but not the specialists or hospital affiliated with the community clinic.”

“Bottom line, as bad as the rural hospital closure crisis already is in many but not all parts of the country, it will become a tidal wave across all of rural America if Medicare, Medicaid and insurance market reforms turn its back on rural providers and the communities they serve.”

By Jeremy Levin, RWHC Director of Advocacy:

Fresh off our annual trip to our Nation’s Capital (the Capitol sits 88 feet above sea level) as part of the National Rural Health Association’s (NRHA’s) 28th annual Rural Health Policy Institute which brings rural leaders from across the country out to DC. This year, we had the largest ever Wisconsin delegation—eighteen—to make these Hill visits.

With a high temperature of 74 degrees for February 8, we were witnessing not only a transition in the seasons, but also a transition in the operation of our government. Only two and a half weeks into the new Trump Administration and there was defi...
nity an air of uncertainty and of the unknown around town.

We urged our Congressional Delegation to protect rural health and not allow us to again become collateral damage due to potential changes that may occur to the US health care system. We asked them to think about how changes might affect rural Wisconsin health care providers: make sure programs like 340B are protected, about which members of the group cited specific examples of how their rural communities have used the savings provided under the 340B drug program to offer or expand other needed health care services locally; Wisconsin gets treated equitably under any new system; and, not to lose the health insurance coverage gains that have been made in recent years.

A response to our trip (and many more like ours) was seen quickly as both of our Senators Tammy Baldwin and Ron Johnson joined a bipartisan group of 41 Senators in sending Secretary Price a letter underscoring the importance of rural health care and urging him to work together with Congress to improve and protect rural health. As the letter states, “Rural hospitals play a critical role in communities across the country... In addition to providing health care services to surrounding communities, hospitals are often one of the main employers. It is critical we work together as Republicans and Democrats to ensure these hospitals are able to continue to provide care.”

It was refreshing to see the newest members of Congress seek to change the tone in Washington. Wisconsin’s newest member of Congress, Representative Mike Gallagher (R-8th CD WI) joined 45 other Democrat and Republican freshmen members in signing a “Commitment to Civility” pledge. The pledge seeks to “restore collegiality, trust and civility to Congress, encourage productive dialogue, and work to build consensus and the public’s trust in America’s institutions.”

While we still wait to see how policymakers will again alter the US health care system, it is clear that the air of uncertainty and of the unknown keeps many of those working in health care up at night. However, it was positive to see the passion and commitment that our group, and those working in DC on behalf of Wisconsin, to supporting rural communities and the health care that makes them great.

U.S. Bi-Partisan Support for Rural Hospitals

Following is the text from a letter to Thomas E. Price, M.D., Secretary, U.S. Department of Health & Human Services on February 14, 2017, signed by 41 U.S. Senators from both parties:

“As senators representing rural states, we look forward to working with you this Congress to ensure access to quality care and to protect the viability of facilities in rural America. Almost 90 percent of our nation is geographically rural, with 20 percent of the population living outside urban areas, often miles away from a health care practitioner.”

“We appreciate your focus on rural America and look forward to working with you and President Trump to strengthen access to health care services in vulnerable rural communities across the country. Health
care is constantly evolving in our country, and rural providers, patients, and facilities need reliable partners at all levels in order to be successful.”

“Rural hospitals play a critical role in communities across this country. In addition to providing health care services to surrounding communities, hospitals are often one of the main employers. It is critical we work together as Republicans and Democrats to ensure these hospitals are able to continue to provide care.”

“We recognize that providers need to adapt to changes in the delivery of health care. We are encouraged by innovations we have seen in our states as providers test new care models and technologies like telehealth and remote patient monitoring. We know you will find bipartisan interest in supporting these types of innovations, and we look forward to working with you to improve our health-care system. We recognize the importance of tackling this issue in a fiscally responsible way but believe investments in rural America yield substantial returns on investment.”

“As you take on this new leadership role at HHS, we request that you work with us to ensure that the federal government does not act as an impediment to providing health care in rural communities. Overreaching and onerous regulations from Washington disproportionately harm rural America. We believe that together we can enact and implement effective policies that help providers innovate in care delivery and enable them to make efficient use of available resources.”

“We hope you remain dedicated to ensuring all Americans—no matter where they live—have access to quality, affordable care. We look forward to continuing to work with you as we move forward to improve health care in rural America.”

Roger F. Wicker (MS), Jon Tester (MT), Chuck Grassley (IA), Heidi Heitkamp (ND), Al Franken (NY), John Boozman (AR), Shelley Moore Capito (WV), John Thune (SD), Joni K. Ernst (IA), Thad Cochran (MS), Tammy Baldwin (WI), James Lankford (OK), Pat Roberts (KS), James M. Inhofe (OK), Roy Blunt (MO), Angus S. King, Jr. (ME), David Perdue (GA), John McCain (AZ), Tom Udall (NM), Sherrod Brown (OH), Steve Daines (MT), Joe Manchin III (WV), Jeanne Shaheen (NH), John Barrasso (WY), John Hoeven (ND), Robert P. Casey, Jr. (PA), Amy Klobuchar (MN), Michael B. Enzki (WY), Ron Johnson (WI), Dean Heller (NV), Susan M. Collins (ME), Deb Fischer (NE), Cory Gardner (CO), Lindsey O. Graham (SC), M. Michael Rounds (SD), Joe Donnelly (IN), James E. Risch (ID), Mike Crapo (ID), Lisa Murkowski (AK), Todd Young (IN), Jerry Moran (KS)

The Heroism of Incremental Care

From “The Heroism of Incremental Care: We devote vast resources to intensive, one-off procedures, while starving the kind of steady, intimate care that often helps people more.” by Atul Gawande, (a surgeon, public health researcher and a New Yorker staff writer) in The New Yorker, 1/23/17:

“A torrent of blood poured out of a fissure on the spleen’s surface. The attending surgeon put a clamp across its tether of blood vessels.”

“The bleeding stopped instantly.”

“The patient was saved.”

“How can anyone not love that? I knew there was a place for prevention and maintenance and incremental progress against difficult problems. But this seemed like the real work of saving lives. Surgery was a definitive intervention at a critical moment in a person’s life, with a clear, calculable, frequently transformative outcome.”

“Fields like primary-care medicine seemed, by comparison, squishy and uncertain. How of-
ten could you really achieve victories by inveigling patients to take their medicines when less than half really do; to lose weight when only a small fraction can keep it off; to quit smoking; to deal with their alcohol problem; to show up for their annual physical, which doesn’t seem to make that much difference anyway? I wanted to know I was doing work that would matter. I decided to go into surgery.”

“Not long ago, I was talking to Asaf Bitton, a thirty-nine-year old internist I work with, about the contrast between his work and mine, and I made the mistake of saying that I had more opportunities to make a clear difference in people’s lives. He was having none of it. Primary care, he countered, is the medical profession that has the greatest all-over impact, including lower mortality and better health, not to mention lower medical costs. Asaf is a recognized expert on the delivery of primary health care around the world, and, over the next few days, he sent me evidence for his claims.”

“He showed me studies demonstrating that states with higher ratios of primary-care physicians have lower rates of general mortality, infant mortality, and mortality from specific conditions such as heart disease and stroke. Other studies found that people with a primary-care physician as their usual source of care had lower subsequent five-year mortality rates than others, regardless of their initial health. In the United Kingdom, where family physicians are paid to practice in deprived are-

as, a ten-percent increase in the primary-care supply was shown to improve people’s health so much that you could add ten years to everyone’s life and still not match the benefit.”

“Another study examined health-care reforms in Spain that focused on strengthening primary care in various regions—by, for instance, building more clinics, extending their hours, and paying for home visits. After ten years, mortality fell in the areas where the reforms were made, and it fell more in those areas which received the reforms earlier. Likewise, reforms in California that provided all Medicaid recipients with primary-care physicians resulted in lower hospitalization rates. By contrast, private Medicare plans that increased co-payments for primary-care visits—and thereby reduced such visits—saw increased hospitalization rates. Further, the more complex a person’s medical needs are the greater the benefit of primary care.”

“I finally had to submit. Primary care, it seemed, does a lot of good for people—maybe even more good, in the long run, than I will as a surgeon.”

“The Importance of Place to Rural Health

From “The Intimacy of Place: Lessons for Philanthropy” by Kathleen Belanger in The Rural Monitor, 5/17/12

“According to the T.L.L. Temple Foundation’s Buddy Zeagler: ‘Life is kind of like traveling down the Mississippi River. Everyone gets a canoe and a paddle. Now we can fight the river, or let its current carry us. We can go happy or sad. We can help others into our canoe or not. But one thing is certain—we’re all going to New Orleans. And the single question we may be asked when we get there is this: did you comfort the heart of at least one person who had lost all hope for peace?’ This kind of comfort, this basic help, the intimacy of place is the strength of rural communities.”

“As Wendell Berry said, in his book, The Long-Legged House, ‘A community is the mental and spiritual condition of knowing that the place is shared, and that the people who share the place define and limit the possibilities of each other’s lives. It is the knowledge that people have of each other, their concern for each other, their trust in each other, the freedom with which they come and go among themselves.’ “

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to pay off. But this is also an opportunity. We have the chance to transform the course of our lives.”

“Doing so will mean discovering the heroism of the incremental. That means not only continuing our work to make sure everyone has health insurance but also accelerating efforts begun under health reform to restructure the way we deliver and pay for health care. Much can be debated about how: there are, for example, many ways to reward clinicians when they work together and devise new methods for improving lives and averting costs. But the basic decision has the stark urgency of right and wrong.”

“We can give up an antiquated set of priorities and shift our focus from rescue medicine to lifelong incremental care. Or we can leave millions of people to suffer and die from conditions that, increasingly, can be predicted and managed. This isn’t a bloodless policy choice; it’s a medical emergency.”

**Leadership Insights: “Change Challenges-I”**

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

More “change challenge” Q&A next month. **Do you have a specific question about leading change? Let me know at jpreston@rwhc.com.**

“If you want to lead change, you owe it to yourself to learn best practice and here is a great place to start:  
http://ow.ly/A0nj309b9Dz  
Implementing in real life, though, can hit some bumps.”

**How do I get my manager/higher ups to buy into a change and be accountable for a behavior?** “It takes guts to coach up the ladder, but remember your leader wants to be successful too. Can you reflect back to them how a behavior or a change could make them look good? A couple of questions to ask: How could I help you with this? What would it take to get your support? What would you need to see or know to give this a try?”

**How do I get long term employees who like things the way they’ve always been to go along with a change?** “It might be that they like things the way they are because that is where they feel competent. Losing a sense of competence can be threatening. Acknowledge this fear while reassuring that you will train and support them in the new way. Ask them to ‘pilot’ the new way for a while to identify the snags so that you can really evaluate it. Say, ‘I need your support and experience. Your role modeling to others the new way will really help us be successful.’ ”

**How do I enforce the new way without being a “cop?”** “Catch someone getting it right and reinforce, ‘That is exactly what I wanted to see, great work!’ If a problem arises, rather than recite the rule, ask the employee what they understand about your expectations. If they can’t articulate it back to you correctly, it’s an opportunity for clarification. Ask what is needed from you to be successful going forward. Listen for underlying needs and doubts. Too often we underestimate others’ learning curves. Find your early adopters and supporters and ask for their help to lead the way–you can’t change much of anything alone. And sometimes you will have to address underperformance.”

**What if I am upholding a change that has been implemented, but my peers are not following it with their staff?** My team feels it is unfair. “More than unfair, it is a morale killer. Talk to the individual leader and share the impact their actions are having on your team. Ask what it would take to get buy in. Bring the question to your leadership team and hash it out openly–don’t leave the room until everyone says ‘I’m in’ or ‘I still have questions’ and they get them answered.”
How do I move a change forward when it stalls out? “Revisit your vision of what you want from the change. Ask if people are still clear about where you are headed and if not, you may need to reboot the ‘destination postcard’ discussion. Is there still something at stake if you don’t change? If not, people will move on to other things. You may need to remind people of the sense of urgency.”

How do I hardwire a change? “Reinforce successes. Tell stories about how the change makes a difference, about how it has led to something better. Find ways to make it easier to do things the new way than the old way. Remind the overwhelmed of other changes they have been successful at that are now just second nature—and this one will be, too. Ask people how they are doing with the change, what they are learning, where they still need help (and make that happen), what is getting in their way (and move it over).”

How do I manage a bunch of new changes when nothing ever goes away, it just keeps piling on? And, how much change is too much change? “This is a tough question. In short, when a new change is initiated, it is fair to ask for a change project plan. It should identify the urgency, vision, stakeholders, team members needed, timeframe for milestones, role clarification, work time estimate, and scope (what is included and what is not). Don’t set yourself up for failure and overload by saying yes before you know what you are saying yes to.”

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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