Celebrating Rural Hospitals

From “Celebrating Rural Hospitals, the 20th Anniversary of Critical Access,” a talk by Tim Size in Washington, DC before the National Rural Health Policy Institute on February 6th, 2018. Editors Note: In the early hours of February 9, both the U.S. Senate and House passed a Bill that included many of the provisions asked for in this commentary:

“I am honored to be here to help celebrate rural hospitals—in particular, the 20th anniversary of the first generation of Critical Access Hospitals (CAHs). While CAHs are a critically important Medicare innovation, I am also here to say that rural hospitals are fundamentally not defined by a collection of federal or state regulations or payments.”

“Rural hospitals are defined by the communities we serve; if we don’t match that vision, they vote with their feet whether or not the hospital is a nonprofit, locally governed or part of a larger system.”

“CAHs were by no means created overnight. Their creation in the Balanced Budget Act of 1997 was the result of over a decade of advocacy and hard work triggered by the ill-conceived application of Medicare’s Prospective Payment System (PPS) to lower volume rural hospitals.”

“As most of you may know, PPS led to the rural hospital closure crisis in the mid-1980s and early 1990s. Along the way, a widespread acceptance developed that the design of PPS was flawed and that it negatively impacted on rural hospitals in ways that made neither professional nor political sense.”

“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, the loss of local care during a medical emergency.”

“For the rest of us it created a strong feeling of being undermined by our own government and it reinforced the myth that rural wasn’t very important—that we didn’t need local rural healthcare. Not unlike the feeling that many of us have today with the unjustified Medicare cuts and urban centric regulations that still remain in place.”

“It really should not have been a surprise that PPS would be a disaster for rural communities. It started by carving rural hospitals out from all other hospitals and giving them their own lower national base rate. They then added a flawed wage adjustment to further lower rural reimbursement as well as a system of individual payment groups driven by diagnosis related groups that needed large hospital volumes to smooth over its rough edges.”

“Building the awareness that PPS didn’t fit rural took time and many advocates, including the then newly

“Whenever you find that you are on the side of the majority, it is time to pause and reflect.” - Mark Twain

RWHC Eye On Health, 2/14/18
established national network of State Offices of Rural Health. But our mission was clear, we were fighting for equity, for local access to care and for local jobs. One of our longest and most effective PR campaigns in Wisconsin was entitled ‘Medicare–Same Tax, Different Benefit.’ ”

“People often know that business relocation decisions are influenced by the cost and quality of the health care available locally. But as or more importantly, rural health has the same economic impact as export commodities like milk, soybeans or rural manufactured goods because of its own ability to bring dollars and jobs into our rural communities.”

“Rural insurance premiums and taxes only come back to circulate in the community and create jobs if there are local health care providers there (and people use them) to attract those dollars. For every two jobs created (or lost) in rural health care, the number of jobs in other local businesses increase (or decrease) by one job.”

“To give our cause further visibility, the National Rural Health Association (NRHA) sponsored a class action law suit against the Department of Health and Human Services. The claim was that the relatively lower PPS payment rates for rural hospitals constituted a ‘taking without just compensation,’ a violation of the Due Process guarantee of the Fifth Amendment to the Constitution by unconstitutionally burdening a class of rural hospitals with the cost of subsidizing Medicare operations at their respective hospitals.”

“While our constitutional challenge was eventually dismissed on technical grounds, it was very clear at the time that the credible pursuit by NRHA of this lawsuit played a significant role in focusing attention on the seriousness of the structural defects in PPS and the need for Congressional action.”

“While there have been and undoubtedly will continue to be changes to what constitutes the provider type Medicare calls a CAH, there is one thing that will not change and that is what is a rural hospital.”

“While some have tried to rewrite history, it is my certain memory that when CAHs began there was a limit on how many beds a CAH could have but there was no minimum number of beds required. Yes, you heard me right, the original CAH concept included the idea that a rural hospital could have no inpatient beds. Even back in the early days of NRHA, we understood that there was a need for flexibility and the ability to right size a hospital to a community.”

“A rural hospital is not defined by the government but by the friends and neighbors the hospital serves and by the people who govern or advise the provision of local care. This definition may include beds or not and increasingly includes partnership with the community outside of the walls of the hospital to make the local population healthier. Additional models such as proposed in the Save Rural Hospitals Act would give needed flexibility to right size local services.”

“But FIRST we must continue to fight to reverse the death by a thousand cuts that rural hospitals have sustained in recent years; we need:

- Elimination of Medicare Sequestration for rural hospitals;
- Reversal of “bad debt” reimbursement cuts;
- Permanent extension of current Low-Volume and Medicare Dependent Hospital payment levels;
- Reinstatement of Sole Community Hospital “Hold Harmless” payments;
- Extension of Medicaid primary care payments;
Elimination of Medicare and Medicaid DSH payment reductions;
Establishment of Meaningful Use support payments for rural facilities; and
Permanent extension of the rural ambulance and super-rural ambulance payment.”

“And last but not least, assurance of full funding under the 340B pharmacy and swing bed programs.”

“We have been here before. We will do well if we speak with a united voice.”

Rebuilding Rural Infrastructure

The following is from http://rebuildrural.com:

“The Rebuild Rural Infrastructure Coalition is comprised of more than 200 organizations from across the country focused on rural communities, U.S. agricultural producers, rural businesses, and rural families. The Coalition is dedicated to advocating for investment in rural America’s infrastructure and understands that rural America’s infrastructure needs are fundamentally different.”

“Past infrastructure initiatives often focused on urban and suburban areas while not adequately addressing the unique needs of rural communities. Rural communities have seen their infrastructure deteriorate, jeopardizing their jobs, their families’ health and wellbeing and their competitiveness in both agricultural and other industries important to rural America.”

“American agriculture feeds the world and creates millions of jobs for U.S. workers. Our nation’s ability to produce food and fiber and transport it efficiently across the globe is a critical factor in U.S. competitiveness internationally. Our deteriorating infrastructure negatively impacts the ability of rural Americans to do their jobs.”

“Transportation infrastructure improvement to highways, bridges, railways, dams, harbors and port facilities is the most obvious need in rural communities, but not the only need that must be addressed. In addition, critical needs exist in providing clean water for rural families, affordable housing options for rural residents, expanding broadband options to connect rural communities to the outside world, updating Ag research facilities so the rural economy can stay competitive and enhancing the ability to supply affordable, reliable and secure power for the rural economy.”

“Federal investment in infrastructure plays a vital role in repairing and expanding our nation’s infrastructure, however federal funds cannot fully meet the vast diversity of needs. This is why public-private partnerships and other creative solutions are necessary to meet the challenges of rural America. In order for infrastructure funding to be utilized to the highest degree, we must ease burdensome regulations and outdated statutory requirements, as well as fund projects in a way that ensures completion in a timely manner.”

Rebuild Rural Issues

Ag Research

- Federal government should continue its history of supporting agricultural research.
- Cutting-edge research is being conducted in outdated agriculture research infrastructure.
- $8.4 billion in total deferred maintenance outstanding in Ag Research building and infrastructure.

Healthcare

- 80 rural hospitals closed since 2010, 673 facilities are vulnerable, making up 1/3+ of facilities.
Funding needed for 77% of rural counties in Primary Care Health Professional Shortage Areas.
Telehealth, combined with broadband, facilitates early diagnosis and treatment in rural areas that can lead to lower health care costs.

Broadband

- Broadband is vital to economic development, education, agriculture, health care and public safety.
- The High-Cost Universal Service Fund lacks sufficient resources to reach rate/service parity for rural and urban areas.
- Less federal regulatory burden for permits and access to government lands would boost investment in rural broadband.

Housing

- Low income rural Americans depend on multi-family housing loans through USDA Rural Development.
- Need to modernize housing programs such as MPR and Section 538 and Section 521.
- Rural communities need senior care facilities, higher proportion of population over 50 years old.

Energy

- RUS loan program helps modernize the grid, combat cyber threats and integrate renewable energy.
- RUS loans produce net income for the Treasury - approximately $300 million in 2016.
- Reducing the regulatory burden on RUS loans and infrastructure siting would increase development.

Transportation

- Most of our locks and dams are dilapidated and have outlived their 50-year design lifespan.
- Waterways are critical corridors of commerce and supported $128 billion in ag exports in 2015.
- Most of the US transportation system is rural: 74% of bridges and 73% of roads.

Financing

- Access to affordable and long-term financing options is critical for rural infrastructure projects.
- Rural infrastructure facilities often are smaller, don’t attract major financial institutions.
- Federal funding often is limited for rural projects, private sector financing partners are needed.

Water

- 94%+ of U.S. drinking water utilities supply communities with fewer than 10,000 persons.
- USDA Water and Waste Water program backlog is $2.5 billion, with 995 pending applications.
- Aging and deteriorating systems beyond their useful life with the greatest health needs, need priority.

Think Beyond the Sound Bite

From the Findings Brief, “Range Matters: Rural Averages Can Conceal Important Information” by Meagan Clawar, Kristie Thompson and George H. Pink at the NC Rural Health Research Program, 1/18:

“Researchers often use averages to describe data. The average (or the mean) of a data set can be used to identify the central value of the group, or what is typical. While valuable, it’s also important to understand the range of data—the highs and lows. What might we miss
by focusing on the average?”

“When considering averages, important questions to ask are: Are the data distributed normally creating a bell-shaped curve? Are the data skewed to one side leaving a tail at either end? When the data are skewed, the average is pulled to one side and is no longer located in the center; thus, the average would not be an appropriate representation of the typical value in the group. Even with normal distribution, considering the range of data values is imperative.”

“An Example: ‘The average rural hospital was profitable in 2015.’ A common measure of profitability is total margin, defined as net income divided by total revenue and reflected as a percentage. If total margin is positive, this indicates that revenue is greater than expenses, and the organization is profitable. In contrast, if total margin is negative, the organization is unprofitable. Profitability is of obvious importance as hospitals need to maintain the necessary infrastructure (building, equipment, staff, technology) to provide services to the population.”

“Figure 1 shows the 2015 total margin for every rural hospital in the country (2,258 hospitals). In 2015, the average total margin for rural hospitals was 1.8% indicating that the average rural hospital was profitable in 2015. However, 849 rural hospitals (38%) were unprofitable in 2015 (they had negative total margins as shown by the yellow bars). The average total margin is positive 1.8% because the number of profitable hospitals (1,409) is greater than the number of unprofitable hospitals, but there is still a large number of unprofitable hospitals. Although 1.8% is a relatively small number and may suggest a narrow range of profitability, in reality, some rural hospitals were very unprofitable (~60%) and some were very profitable (+60%).”

“While it is true that the average rural hospital was profitable in 2015, it would be wrong to conclude that profitability is not a problem for rural hospitals considering a substantial proportion of rural hospitals were unprofitable. It would also be erroneous to conclude that all rural hospitals are barely profitable—a considerable proportion of rural hospitals had substantial total margins (both negative and positive). “

Above is just one of three examples from the complete brief at: www.shepscenter.unc.edu.

Healthcare’s Invisible Workforce

From “President Signs Law to Support Family Caregivers: AARP-backed RAISE Family Caregivers Act creates a strategy to support millions who help loved ones remain in their homes” at www.aarp.org on 1/24:

“The president has signed into law an AARP-backed bill that requires the federal government to develop a strategy to support the 40 million Americans who care for a loved one.”

“The measure—the Recognize, Assist, Include, Support and En-
gage (RAISE) Family Caregivers Act directs the Department of Health and Human Services to create an advisory council charged with making recommendations on the strategy to support family caregivers. The blueprint, which must be developed within 18 months, would address financial and workplace issues, respite care and other ways to support caregivers.”

“AARP worked closely with the bill’s sponsors to develop the legislation and with lawmakers to get the measure passed in an effort to help the nation’s family caregivers. ‘Family caregivers are the backbone of our care system in America,’ said Nancy A. LeaMond, AARP’s chief advocacy and engagement officer. ‘We need to make it easier for them to coordinate care for their loved ones, get information and resources and take a break so they can rest and recharge.’ ”

“Every year, family caregivers provide about 37 billion hours of unpaid help for their loved ones. Caregivers often are responsible for managing a loved one’s medications and other health needs, as well as preparing meals and doing housework. Many provide this care while working full time and raising their own families. About 32 percent of family caregivers provide at least 21 hours of care a week.”

“LeaMond said that thanks to the efforts of the bipartisan bill’s champions—Sens. Susan Collins (R-Maine) and Tammy Baldwin (D-Wis.), and Reps. Gregg Harper (R-Miss.) and Kathy Castor (D-Fla.)—the RAISE Family Caregivers Act will help address the challenges family caregivers face.”

Turning Students on to Health Careers

RWHC partnered with the Student & Leaders Network (SLN) to create two live streaming/recorded career programs for Wisconsin high school and junior high students to promote rural pharmacy practice and men in nursing. The programs highlighted the stories of two RWHC partners, sharing guidance for students, teachers and parents about important facets of these careers and helping young people see into the daily lives of pharmacy and nursing work.

Cindy Kissack, Director of Pharmacy at St. Clare’s Hospital in Baraboo and a RWHC Pharmacy Roundtable member, spoke about the “Pharmacist: More Than Just Counting Pills.”

Jeremiah Galvan, RN, Clinical Manager of Critical Care, Gundersen Health System and a member of RWHC Men in Nursing Roundtable, spoke about “Being A Nurse: Caring Beyond the Bedside.”
These programs, along with many others reach over 140,000 Wisconsin students each year and are available at:

www.studentcareerinfo.com

SLN, a 501(c)3 nonprofit serves as a bridge to identify and involve Wisconsin experts and leaders with the Wisconsin educational system by providing live, interactive web conferencing and digitally stored video discussions on topics that provide information and insight on careers and life challenges for students, educators and parents. The program is free to schools.”

Leadership Insights: “Receiving Feedback”

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

Gracefully Receiving Feedback–“It’s not always easy to be on the receiving end of feedback. As stated in last month’s newsletter on delivering feedback, that half of the equation is hard enough. Even when managed skillfully though, tough feedback can still come as a surprise. The receiver senses a threat to their freedom, their sense of competence or control, and it can be a breeding ground for hurt feelings and misunderstandings.”

“When we are fearful or angry, we stop listening and start justifying, missing the nugget of wisdom that might be there. To consciously manage ourselves in those challenging moments and achieve the benefit of feedback:

Breathe–One of the first things many of us unconsciously do when we feel threatened is to stop breathing deeply, even holding our breath. Less oxygen really limits our ability to act thoughtfully. We need the oxygen to calm ourselves. Stop, exhale every bit of air you can and then inhale deeply a couple of times and you will be better able to hear.

‘Tell me more’–Instead of the inclination to explain or justify, say ‘Tell me more.’ It gives you time to learn more about the real issue, seek specific examples to better understand what the concern is, and time to manage your response.

Ask for time–If defenses kick up, it may not be the best time to dialogue, so ask to meet later, perhaps something like, ‘Discussing what you have to share is important to me. I have another obligation right now, but can we meet in a half-hour?’ ”

Thank them–Especially if you are in a higher level position, and even if you are not all that happy to hear what they have to say, say thank you. This keeps communication open for the future and it is important to keep that door from closing. Feedback is actually a gift if we choose to be open to seeing it that way, and saying thank you helps us to remember that.

Remind yourself–That you want to be effective, to grow and to learn. All information is useful to that end. You may not agree with it, but in thoughtfully considering it, you will learn more about your impact on others.

It is ok to say, ‘This is hard to hear’–It is a misconception that leaders must always appear tough, like nothing bothers you or makes you sweat. To build
trust one must show vulnerability. Is the feedback given to you something that makes you feel vulnerable or exposed? How you authentically demonstrate that you are taking a tough message to heart can confirm with the other person that you do care and are willing to reflect on their message.

Assume good intent on the other person’s part–There are many assumptions we jump to make, but the only helpful one is to remember, ‘This person very likely has my best interests in mind and wants what is best for me.’ Take a walk around the block or the building and put a STOP SIGN up to the stories you are creating in your head about the other persons’ intentions. Maybe their intentions are evil, but assuming so is a no-win approach.

Actively listen–Want to be a more skillful communicator overall? Listen better. Reflect what you understood them to mean to make sure you are understanding them right.

ASK for more feedback regularly–It gets you used to receiving it which takes out some of the sting. It also keeps you learning and gains you respect from your team, and has the potential to help you be a better leader.

Extend trust–Even if your trust is not in the person delivering the feedback, bring trust to the front of your mind. Trust in yourself to manage your emotions; trust that something good can come from a difficult conversation; trust that you will get through whatever may come of this feedback because you have gotten through other difficult things, too, and have grown from them.”

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.

Upcoming RWHC Leadership Programs
3/09 – Monkey Management (Based on The One Minute Manager)
3/23 – Dealing with Disruptive Behaviors
4/03 – Project Management and Team Facilitation (New)
Non-Members Welcome. Register & other events at: www.RWHC.com/Services.aspx