Review & Commentary on Health Policy Issues for a Rural Perspective – March 1, 2020

Rural Ecosystem Impact on Rural Hospitals

From “Wisconsin largely avoids rural hospital closures, but faces challenges” in Wisconsin Health News, 2/13/20:

“Wisconsin has largely avoided the rural hospital closures that other states have faced. But rural hospitals and communities still face a host of challenges, hospital groups say.”

“This week, the Chartis Center for Rural Health released a report cautioning that a dozen Wisconsin hospitals are vulnerable to closure. Three were considered ‘most vulnerable,’ and nine were considered ‘at risk.’ ”

“The center declined to identify the hospitals. Billy Balfour, Chartis’ spokesman, said it’s the first time they’ve taken a deep dive into hospital vulnerability.”

“Between the start of 2010 to the end of last year, 120 rural hospitals closed in the United States, with 19 shuttering in 2019, according to the report. Texas, Tennessee, Oklahoma, Georgia, Alabama and Missouri saw the largest number of rural hospital closures in the last decade.”

“In Wisconsin, one rural hospital closed during that period. Franciscan Skemp, part of Mayo Clinic Health System, shuttered its Arcadia hospital in 2011 and built a clinic in the city instead.”

“Tim Size, executive director of the Rural Wisconsin Health Cooperative, said some rural hospitals are struggling in Wisconsin. He’s not aware of any at ‘imminent threat’ of closing. ‘I see what’s going on in the country, and sooner or later, that wave comes to Wisconsin,’ he said. ‘I just don’t believe that it’s come yet. I don’t want people to be unduly panicked in Wisconsin. On the other hand, I think we have to understand there’s something going on.’ ”

“Size noted that he has one concern about the report. For instance, the authors classified Wisconsin as a non-Medicaid expansion state even though it did a partial expansion of the program. ‘We probably don’t fit readily into their analysis.”

“Balfour of Chartis said they used the Kaiser Family Foundation for tracking the states that are expanding and aren’t. He noted that expansion was one of nine variables that proved statistically relevant in the model.’ ”

“Size said the report says more about the challenges facing the ‘rural ecosystem’ than individual hospitals. Some of those challenges have to do with healthcare reimbursement, as rural patients are less likely to be covered by private insurance. That leaves hospitals more vulnerable to government payers that cover less than the full share of costs, according to Size.”

“The best way to predict your future is to create it.” - Abraham Lincoln

RWHC Eye On Health, 2/18/20
“There’s also potential for insurers to steer patients away from rural communities, Size noted. Rural hospitals are more at risk for bad debt from patients with high-deductible plans, he added.”

“‘Rural hospitals are also the safety net for the community and don’t have the option to cut services if they lose money, he said. We need more reasonable reimbursement from the federal government around Medicare because that is the big payer for rural,’ Size said. ‘If they’re not paying their share of the cost, then that’s a problem.’ ”

“Rural communities face ongoing shortages of providers. On top of that, there are barriers to recruitment to rural Wisconsin, like a lack of affordable housing and child care.”

“Rural Wisconsin has also been slow to recover from the Great Recession compared to the rest of the state. And counties have seen their populations drop, Size noted. ‘We need to rebuild the rural economy,’ he said. ‘We need to get better at getting people into Wisconsin as a whole and into rural Wisconsin. We have some major systems problems, and it cuts across health and the rest of our economy and social network.’ ”

“Wisconsin has been able to use public policy very effectively,’ he said. ‘The things that we get passed and enacted are very targeted and very impactful and they do move that needle. But I also want to say that we are blessed in this state to have some incredible hospital and health system leaders.’ ”

“While we clearly have challenges that we know and we have to address and keep working to address, so far, I think we’ve done a relatively good job of assisting our rural hospitals and our rural health systems,’ he said.”

“He said that work has helped ‘blunt’ some of the trends that other states have faced. But he said that doesn’t mean the state is OK, noting that there are rural hospitals operating in the red, demographic changes, and outmigration from rural areas.”

“He said that WHA collaborates with the Rural Wisconsin Health Cooperative on public policy, including lobbying on Medicare reimbursement and protecting and preserving the critical access hospital program. They’ve also pushed for increased funding for state programs, like increasing money for disproportionate share hospital payments and the rural critical care hospital supplement program.”

“‘Wisconsin Hospital Association CEO Eric Borgerding said that the rural hospital closure makes Wisconsin a ‘bit of an anomaly’ compared to other states.’”

“Other efforts have targeted the workforce. Borgerding said Wisconsin has worked on expanding healthcare professional training programs and knocking down barriers to allow providers to practice at the top of their license.”

“And Borgerding said they’re also focused on how to support non-healthcare sectors in rural areas, looking at ways to boost rural economic development like broadband expansion and affordable housing.”

**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.

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“He cautioned that this is a long-term project for addressing the rural challenges and that the state is not ‘out of the woods.’”

“We’re not waiting for the rural hospital crisis to befall our state; we are working hard to get in front of and prevent it,” Borgerding said. “Whether we can do that or not, only time and sound public policy will certainly tell.”

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Rural Troubles–Strong Support

By Jeremy Levin, RWHC Director of Advocacy

An energetic group of Wisconsin rural health advocates are just back from a wet and dreary trip to our Nation’s capital. We went to advocate as part of the National Rural Health Association’s (NRHA’s) 31st annual Rural Health Policy Institute, that brings rural leaders from across the country out to DC to learn and lead.

We urged our Congressional Delegation to support efforts to improve health care price transparency, which many rural Wisconsin hospitals already voluntarily provide consumers with various pricing tools. Our position is that an independent dispute resolution (arbitration or mediation) process would best protect patients from surprise medical bills. These surprises rarely occur in Wisconsin’s rural hospitals, and independent dispute resolution would be better than a top-down, one-size-fits-all imposition of benchmark rates. Benchmark rates will have unintended negative consequences for rural hospitals and patients as provider networks will undoubtedly shrink.

We also asked our Congressional Delegation to focus in on the unrelenting pressures on providing mental health care, which is becoming more scarce in rural communities across Wisconsin even though rates of depression and suicide are higher in rural areas. We will work with our delegation to make sure Wisconsin leads efforts to stave off the closure of rural psychiatric units at rural hospitals due to the unsustainable reimbursements by governmental payers.

As always, it was positive to see the passion and commitment that our group and those working in DC on behalf of Wisconsin have in supporting rural communities and the health care that makes them great.

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Rural: Wasteland or Pastoral Cornucopia?

From an Editor’s Note, “Rural America and a Tale of Two Columnists” by Tim Marema in the Daily Yonder, 8/09/19:

“Americans have a couple of ways they tend to think about rural America. On one side of the coin, we see it as a post-apocalyptic wasteland of dysfunction, intolerance, and economic ruin.”

“On the other, we see a pastoral cornucopia of small-town charm, neighbor helping neighbor, and homegrown tomatoes. In other words, it’s all bad or all good.”

“Two New York Times published columns by Paul Krugman and David Brooks that fit these all-or-nothing patterns to a T. Krugman wrote about the economic dysfunction of rural America, saying unstoppable forces prevent widespread rural economic recovery. ‘There are powerful forces behind the … economic decline of rural America–and the truth is that nobody knows how to reverse those forces.’ ”

“Brooks, on the other hand, wrote about the positive aspects
rural civic life he has observed first-hand in visits to small towns in Nebraska. ‘I keep going to places with more moral coherence and social commitment than we have in booming urban areas.’ ”

“With just a few words, the economist (Krugman) and the moralist (Brooks) trigger our customary response to rural America. It’s so busted it can’t be fixed, or it’s so naturally good we must tread lightly lest we corrupt it. Either way, if you buy those stories, there’s not much American society can do collectively to help improve conditions in rural America. If it’s economically hopeless, why bother? If it’s morally superior, just let them figure it out on their own.”

“Both columnists are raising fundamental questions about the future of rural America. Both present parts of the story accurately. There’s nothing malicious about either column, necessarily. (Although there’s always speculation that the two men are fighting a passive-aggressive proxy war because the Times discourages direct debate between their columnists.)”

“But the binary, us-against-them framing of the rural question misses a far more important point. The future of rural America isn’t separate from the future of urban America. This isn’t a zero-sum game. It’s possible for rural and urban areas to succeed simultaneously, and by doing so, each part of the country helps the other part build a better future. Rural and urban areas depend on each other. That is why they both matter—not because one is more economically productive or the other is morally superior.”

“The reality is that rural and urban areas depend on each other. Each offers the other economic, cultural, social, and environmental necessities. When rural and urban are in tune, the success of one contributes to the success of the other. And, the corollary is also true: When one falters, the other is likely to experience loss.”

“There are plenty of examples. Metropolitan areas are the market hubs for their surrounding rural regions. Rural counties that are closer to metropolitan counties have fared better economically and demographically than more remote counties in the recovery from the 2008 recession. Metropolitan regions provide opportunities for rural young people who want advanced education and urban-focused careers. Metropolitan areas provide access to more specialized healthcare and other services that are easier to provide at higher population densities.”

“Conversely, rural communities provide the food, fiber, and energy that cities cannot generate for themselves. We can’t address green-energy and climate-change challenges without strong rural participation. Urban America needs rural stewards who harness the productivity of rural America while ensuring its sustainability. We all win if that happens.”

“Rural communities offer a lower cost of living than cities. Lower population density changes human interaction and connection. We are more likely to know our neighbors and participate in social, civic, and religious activities. These are skills we desperately need these days, and rural America has a unique way of teaching them. That doesn’t mean rural Americans are morally superior to urban ones. The scale of human interaction tends to be more personal in rural communities, and that affects the nature of our relationships.”

“Rural and urban have become shorthand for political division and tribalism that pundits say are the hallmarks of our current civic discourse. The reality is that the rural-urban dichotomy is false. We need leaders and policies that reveal that falsity and create a new path forward for us all.”
“How Police Officers Can Save Rural EMS”

By Aditya Shekhar in the Journal of Emergency Medical Services, 1/14/20:

“In recent months, the shortage of personnel working or volunteering for rural emergency medical services agencies has received a lot of attention. Earlier this year, there was an article in The New Yorker titled “In Rural America, There Are Few People Left to Drive the Ambulances.” In October, a report on NBC Nightly News shed further light on this shortage and its effects. Citing various reports, they noted that 70% of rural EMS agencies rely on volunteers and 1/3 of these EMS agencies are in immediate danger of shutting down due to a lack of volunteers. This coincides with the closure of many rural hospitals and community healthcare centers, creating a situation where large portions of rural America are in grave danger of entirely losing access to EMS or any sort of emergency healthcare.”

“Considering how advanced EMS has become — and how much training and continuing education is required—being a volunteer provider can be tough. In cities with ‘career’ EMS departments staffed by full-time personnel, the role that EMTs and paramedics assume is growing, as leaders are embracing an ever-expanding number of interventions. There has been a trend of morphing units from BLS to ALS and even to critical care transports. This growing scope of practice has increased the educational demands placed on EMS providers at all levels, which has made it difficult for unpaid volunteers to commit to the training necessary to become certified.”

“Despite the negative headlines, however, a simple solution might lie in outsourcing rural EMS to other public safety departments. The idea of EMS operating under another department is nothing new. A sizable percentage of ambulances are run by fire departments, and nearly all fire departments respond to medical calls in some way or another. That being said, a public safety organization that has traditionally held a modest role in EMS but, in my opinion, has the potential to transform rural healthcare, is the police department. In specific regions, police officers respond to medical emergencies and, where trained and authorized as providers, routinely provide lifesaving care.”

“There are a lot of challenges facing rural to talk about.

“Vibrant Rural Communities: From Talk to Action” is the theme of the 2020 Wisconsin Rural Summit — an event that brings together people who care about the future of their community. This year’s theme focuses on how small cities, villages and towns are taking positive steps to shape a bright future.

The Rural Summit will be held in Marshfield on April 22-23, 2020. It starts with an optional half day bus tour on Wednesday and features an all-day program on Thursday. Dynamic keynote Deb Brown from SaveYour.town will be followed by break-out sessions on Housing, Renewable Energy, Funding Community Projects, Farm Safety, Natural Resources and more.

The Summit is sponsored by Wisconsin Rural Partners, a statewide nonprofit organization that brings together a cross section of residents, organizations & leaders that cross political affiliations & organizational boundaries to advance initiatives important to rural communities throughout the state.

Other highlights of the Rural Summit include announcement of winners of the Top Rural Development Initiatives awards, Marketplace, plenty of time for networking with fellow attendees and one-on-one follow-up with over 15 speakers.

For more information: https://www.wiruralpartners.org/
rural communities would have at least one medically-trained responder at all times who can respond to medical emergencies and begin providing care. Most, if not all, police cruisers can easily accommodate all the necessary gear to provide basic or advanced life support, including a first-in bag and a defibrillator or cardiac monitor.”

“With officer/EMTs or officer/paramedics, an emergency call would play out something like this: A caller places a 911 call, and dispatchers page the EMS volunteers as normal but also page a cross-trained officer/EMT or officer/paramedic from the police department. Already on-duty and driving a smaller, faster police cruiser, the officer would most likely arrive at the patient well before the EMS service even has the opportunity to gather a crew and respond. The medically-trained officer will be able to provide care to the patient extremely quickly, drastically cutting down current response times. This will allow the volunteer crew to have ample time to safely respond to the station, organize a response team, and drive to the scene, while the patient is already being stabilized and treated by the officer/EMT or officer/paramedic. If the patient does not want to be transported, the officer/EMT or officer/paramedic can cancel the volunteer crew or advise them not to respond.”

“The biggest benefit of the dual-role officer/provider is that once the ambulance arrives, they can assume the role of primary caregiver and continue caring for the patient in the back of the ambulance. This could potentially mean the volunteer crew would not need to be medically trained, since they would just be responsible for driving the ambulance to the scene and during transport to the hospital. Decreasing training requirements would significantly decrease the barrier for entry and the education barriers that are currently plaguing rural EMS. The officer could lock and leave their squad car at the scene or let a member of the volunteer ambulance crew drive the vehicle.”

“Rural communities throughout the country have successfully implemented models where police officers provide advanced medical care to residents. Breezy Point, Minnesota, a town that faces significant seasonal population fluctuation due to summertime tourism, has several police paramedics who can respond to EMS calls and provide advanced life support from equipment kept in their squad cars while waiting for an ambulance from a neighboring community. This model costs the city roughly $14,000, while staffing an ambulance with full-time paramedics and ALS capabilities would run close to $400,000 per year. These officer/paramedics receive training, supplies, and medical direction from an EMS agency in a larger, neighboring community and are authorized to perform the full suite of ALS interventions. For their contributions to rural EMS, Breezy Point’s police paramedics have won several awards, including the Minnesota Ambulance Association Star of Life Award, the Minnesota City of Excellence Award, the Minnesota Chiefs of Police Association Excellence In Innovation award and the Humphrey School of Public Affairs’ Local Government Innovation Award. Another successful police paramedic program has been implemented in North Mankato, Minnesota, where police officers trained as paramedics are authorized to begin ALS-level treatments as an agent of a nearby ambulance service before an ambulance physically arrives.”

“Communities like Sunnyvale, California, Kalamazoo, Michigan, and Woodbury, Minnesota, have even gone a step further by integrating firefighting, EMS and law enforcement into a single ‘Department of Public Safety,’ and staffing it with personnel cross-trained in all three. Their cost per capita for public services is significantly lower than neighboring cities, and this model gives their personnel the flexibility to approach a request for service through a multi-agency lens and brings a varied set of expertise to every call.”

“Cross-trained police officers responding to medical emergencies and staffing ambulances might not work in all communities. Cities, suburbs and communities that can generate enough emergency calls to justify a full-time, dedicated EMS department or have enough medically-trained personnel willing to serve a part-time/paid-on-call/volunteer department might be better off with single-role devoted resources. However, in communities facing a handful of EMS calls that normally rely on willing volunteers for ambulance services, dual-role police officer/providers might be a lifeline between citizens and medical care.”
Leadership Insights: “Friends Accountable?”

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

“A leader asks, “How can we get staff to hold each other accountable when they are friends? They don’t let the manager know, and they don’t say anything directly to the co-worker as they don’t want to jeopardize that friendship. When the problem finally surfaces it is much bigger. We educate people on holding difficult conversations but some still continue to complain to others. It is unfair to the person to not be open and honest and ends up affecting other co-workers and patients.”

“When we continue to let people off the hook for accountability conversations, we are simply confirming that these conversations are optional.”

“Technical skill requirements are not handled this way. You teach someone how to use a machine and state your expectation, ‘Use this machine every time you do X.’ Employee decides next time X happens not to use the machine. The first conversation you have might sound like, ‘I noticed you did not use the machine when X happened. Can you help me understand why?’ Then you sort out the why and problem solve any barriers. You end by asking them to state to you their understanding of your expectations going forward. If they say, ‘You want me to use X if I feel like it but otherwise do what I’m more comfortable with,’ you know you are not done!”

“Communication techniques obviously have an emotional component that technical work doesn’t always have. But both involve skill, clarity of expectation, building safety to do the skill, and identifying purpose. In healthcare, that purpose always includes quality, excellence, safety and service. Following is some ‘handwashing accountability’ theater with M (Manager) and E (Employee):

M–Now that this problem has come to light, it looks like you knew that your friend had been negligent in handwashing. You did not say anything to them directly, but instead talked about it to other co-workers and I am just now learning about this. Can you help me understand why?

E–I felt uncomfortable saying anything. We’re friends and I didn’t want to make them upset with me or make them think I am trying to be their boss or the handwashing police. It’s just so uncomfortable and I had to vent to someone!

M–I understand that it is uncomfortable. There’s always a risk in speaking up like this. But what about the risks of NOT speaking up directly and of gossiping? Can you identify those?

E–“This meeting apparently! I know patients are at risk when we are not diligent with handwashing. But my friendship is important, too, and it’s not fair that I have to be the one to say something. It feels like I am getting in trouble and I wash my hands!”

M–Friends are important, I agree. But this is not personal even though it feels like it. Our number one job is patient quality and safety and not addressing a problem that you see is just as serious as the lack of handwashing. My expectation is that we do everything we can to make patients safe and that includes saying what we see with co-workers—directly with the one involved, not others—when there is a mistake or problem. That is the only way to build trust and safety. I can help you. Let’s walk through some key phrases that you can use and I’ll practice with you:
Open with the friendship and the ‘Don’t/Do’ technique. I need to talk with you about something, and it is hard because we are friends and what I DON’T want is to make you feel bad or like I am trying to be your boss or looking over your shoulder. Because I DO care about you as a friend, it is even more important that I be honest with you!

State what you both care about. I know we both care about staying healthy and keeping patients healthy, too.

Be clear about the behavior—what exactly happened, avoiding labels. I have noticed on several occasions that you do not wash your hands properly before leaving the restroom. A couple of times I have noticed that you did not wash your hands before starting a procedure.

State the effect. This puts the patient—and all of us—at risk of infection.

Ask for what you need. This has to be corrected. I know you don’t want to put anyone at risk.

Reconfirm your friendship. Please know that I am saying this because I care about you. I am coming to you directly and not going behind your back because our relationship is important to me.”

“Once they have practiced this with you, ask the employee to reconfirm with you their understanding of what you expect going forward. Continue dialogue until you hear, ‘You expect me to speak up as part of my job duties, directly to the person involved and not to others, and I can come to you for help.’ ”

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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