“Preserve Our Rural Hospitals”

From “My Turn: Preserve our rural hospitals” by Julie Arel of Starksboro, executive director for the New England Rural Health RoundTable, in the Burlington Free Press, 9/24/13:

“On Aug. 15, the Office of the Inspector General of the Department of Health and Human Services released a report proposing changes that threaten the participation, by many of New England’s rural hospitals, in the Critical Access Hospital program.”

“This program, in place for nearly two decades, is designed to stabilize small rural hospitals and reduce their risk of closure. Critical Access Hospital designation provides qualifying rural hospitals with volume-appropriate Medicare reimbursement along with other regulatory provisions and technical assistance resources, to help maintain access to care in rural areas by improving the financial viability and quality of key services in these small but necessary hospitals.”

“The proposed changes would replace the statutorily granted authority that states had to determine which of their rural hospitals are ‘Necessary Providers’ with a simple drive time distance test between hospitals which does not even take into account the types of services available at each hospital if the other were to fail. These changes, if adopted, could remove the majority of current Critical Access Hospitals across New England from this vital program and could potentially affect the lives of those that live in these communities.”

“Critical Access Hospitals are safety net providers for rural communities and the hubs around which local systems of care are organized. The loss of a hospital in a rural area, therefore, will extend far beyond just the walls of that facility, impacting the economic well-being of the community and access to care at all levels.”

“Without them, many rural residents would experience reduced access to primary, emergency, and acute care services. Critical Access Hospitals serve a disproportionate share of elderly and low-income individuals, populations more heavily impacted by travel barriers. Reduced access due to hospital closures would unduly burden these vulnerable populations.”

“The inspector general’s proposed changes coincide with rising concerns about recent growth in rural hospital closures. Many Critical Access Hospitals already face ongoing financial and operational challenges due to their rural location, workforce shortages, struggling economies, and constrained resources. Critical Access Hospital designation supports them in meeting these challenges while serving their communities. The proposed changes threaten their participation in this important program.”

“In God we trust; all others bring data.” — W. Edwards Deming
“The New England Rural Health RoundTable works closely with Critical Access Hospitals by supporting training initiatives, quality and performance improvement programs, and networking opportunities. We know their commitment to patients and providing high quality, cost effective care. They care for our families and vulnerable populations, employ our neighbors, and provide essential services.”

“Faced with the need to prepare for health reform implementation, and the challenges posed by slow recovery of rural economies, and a new round of rural hospital closures, we question the wisdom of overriding state determination of Necessary Provider status for purposes of Critical Access Hospital program participation.”

“The Critical Access Hospital program, while modest compared to other federal programs, is crucial to rural communities as it successfully fulfills its mission of ensuring access to care and protecting the health of rural residents.”

“‘If you close a hospital, you close the town.’

Secretary Kathleen Sebelius
Department Health and Human Services
The Hagstrom Report, 6/26/13

RWHC Eye On Health

If you close a hospital, you close the town.

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The NP’s scope of practice is governed by state laws and regulations that differ in their requirements for physician supervision and prescriptive authority—the ability to prescribe medications. In rural communities, NPs may be the only available primary care providers, and it is important that they be able to practice independently, if need be, although they value collaboration with physicians and other providers regardless of state authorization.”

“Iowa is one of 22 states where advanced practice registered nurse (APRNs)–NPs, certified nurse midwives, certified registered nurse anesthetists (CRNAs), and clinical nurse specialists–practice without physician oversight and one of 12 states that permit them to prescribe without restriction (Phillips, 2010). Iowa’s APRNs must be nationally certified in their specialty; meet state requirements for continuing education; provide evidence of their education; and collaborate with a physician on ‘medically delegated tasks,’ such as circumcision and hospital admission. Several studies have shown that APRNs produce outcomes comparable to those of physicians and that the care they provide encompasses 80 to 90 percent of the services provided by physicians (Lenz et al., 2004; Mundinger et al., 2000; Office of Technology Assessment, 1986).”

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Emphasized the issue of access to care for rural and disadvantaged populations;

Ensured that policy-makers knew what APRNs do (Ms. Jones invited legislators to her clinic);

Promoted unity among Iowa nursing groups and with organizations such as the Iowa Hospital Association; and

Partnered with leaders, such as former Iowa governor Tom Vilsack (now U.S. secretary of agriculture), the first governor to opt out of Medicare’s requirement that the state’s CRNAs be supervised by physicians.”

“Evidence that it is safe to remove restrictions on APRNs comes from an annual review of state laws and regulations governing APRNs that now includes malpractice claims in its analysis. The 2010 Pearson Report documents no increase in claims registered in the Healthcare Integrity and Protection Data Bank in states where APRNs have full authority to practice and prescribe independently. The report also notes that the overall ratio of claims against NPs is 1 for every 166 NPs in the nation, compared with 1 for every 4 physicians (Pearson, 2010).”

"Where you live matters: For low-income populations, there are wide differences across states in access, quality and safety, and health outcomes."

“Overall, the report finds that there are often two Americas when it comes to health care—divided by geography and income. Wide state differences in health care for low-income populations are particularly pronounced in the areas of affordable access to care, preventive care, dental disease, prescription drug safety, potentially preventable hospitalization, and premature death. Nationally, as of 2010–11, over half (55 percent) of the under-65 population with incomes below 200 percent of poverty—nearly 57 million people—were either uninsured, or if insured, were spending a relatively high share of their incomes on medical care. This is sometimes referred to as being ‘underin-
per centage uninsured or underinsured ranged from a low of 36 percent in Massachusetts to over 60 percent in 10 states (Alaska, Colo., Fla., Idaho, Mont., Nev., N.M., Texas, Utah, and Wyo.).”

“Health system performance for low-income populations in leading states is often better than the national average and high-income populations in other states.”

“The strong performance of leading states and the more positive experiences of low-income or less-educated populations in those states indicate having a low income does not have to mean worse care experiences or health. For all but six indicators, the experiences of low-income individuals in top-performing states exceeded the national average for all incomes. And for half the indicators, including receipt of medications that put health at risk, potentially preventable hospitalization, infant mortality, smoking, and obesity, the leading states’ rates for their low-income populations was better than those of higher-income populations in other states.”

“Upper Midwest and Northeast states and Hawaii performed best overall for low-income populations.”

“The six leading states, Hawaii, Wisconsin, Vermont, Minnesota, Massachusetts, and Connecticut, did well across all four performance dimensions. Each ranked in the top half of states for the majority of the 30 indicators, particularly those related to access, prevention, and treatment. These leading states had among the lowest rates of uninsured adults, contributing to more positive health care and health outcomes.”

“Income-related health care disparities exist within states and across all areas of health system performance.”

“To establish benchmarks for performance, the Scorecard also compared experiences of low-income or less-educated populations in each state to those with higher income (i.e., above 400% of poverty) or more education (i.e., college degree or higher). Lower-income populations are at increased risk of experiencing worse access, lower-quality care—particularly in outpatient settings—and worse health outcomes compared to those with higher incomes in their home state. Income-related disparities were most pronounced on measures of access, prevention, potentially unsafe prescription medication, and health outcomes.”

“Health insurance coverage expansions hold promise to begin closing gaps in primary care and prevention. Broader gains require improvements to health care delivery and a greater focus on population health.”

“Our findings across states indicate that expanding insurance coverage will begin to close the income and geographic divide. In multiple states, insured low-income individuals report a similar rate of having a usual source of care and receiving recommended preventive care as high-income adults.”

Summary: “Improving health system performance for vulnerable populations no matter where people live is within our grasp as a nation. By investing in improving the health of their most vulnerable, states would improve the overall health and economic well-being of their population. Healthier adults are less expensive to care for and have greater workforce productivity; healthier children are more likely to succeed in school and grow up to continue to participate in the workforce in the future. A healthy population is thus instrumental in maintaining strong local and state economies, as well as the nation’s economic health and well-being.”
“State and local care system action that leverages federal resources and builds on national initiatives will be critical to the success of efforts to improve access, health care, and health outcomes, particularly for those vulnerable because of low income. The Scorecard’s findings of high rates of uninsured, low rates of preventive and primary care, variable quality of care, and poor health outcomes for low-income populations underscore the potential gains from focused efforts to:

- “Expand insurance, including Medicaid, and implement policies to hold insurance plans accountable for timely access to provider networks and quality care.”

- “Redesign care delivery systems, supported by payment reform, to provide enhanced, patient-centered primary care within care systems that provide effective, safe and coordinated care, with attention to population needs.”

- “Hold care delivery systems accountable for population health, including collaboration between health care, public health, and community-based services.”

- “Set targets or benchmarks to inform and guide strategic actions to improve.”

From “Physical Activity and Survival After Breast Cancer Diagnosis” by Michelle D. Holmes, MD, DrPH, Wendy Y. Chen, MD, Diane Feskanich, ScD, Candyce H. Kroenke, ScD and Graham A. Colditz, MD, DrPH, in *JAMA*, 5/25/05:

“Physical activity after a breast cancer diagnosis may reduce the risk of death from this disease. The greatest benefit occurred in women who performed the equivalent of walking 3 to 5 hours per week at an average pace, with little evidence of a correlation between increased benefit and greater energy expenditure. Women with breast cancer who follow US physical activity recommendations may improve their survival.”

“Physical activity after a breast cancer diagnosis has been strongly linked to improved quality of life. There is reason to believe that physical activity might extend survival in women with breast cancer.”

“Physical activity also has been linked to a lower risk of breast cancer. An expert panel of the International Agency for Research on Cancer of the World Health Organization estimated a 20% to 40% decrease in the risk of developing breast cancer among the most physically active women, regardless of menopausal status, type, or intensity of activity.”

“Physical activity has been linked to lower levels of circulating ovarian hormones, which may explain the relationship between physical activity and breast cancer. Lower estrogen levels among physically active women with breast cancer could potentially improve survival, although few data exist to support this hypothesis.”

“Lack of physical activity has been shown to be related to weight gain during breast cancer survival. Weight gain after a breast cancer diagnosis is a common adverse effect of treatment. This is important because both being overweight at the time of breast cancer diagnosis and weight gain after diagnosis are linked to poorer survival in many studies. Lack of physical activity is believed to be as im-
important a factor as changes in food intake in the ongoing obesity epidemic.”

“Few have studied associations between physical activity and survival and no studies have assessed physical activity level after diagnosis. Rohan et al found no association between physical activity before diagnosis and survival in a population-based prospective study of 412 women with breast cancer. We hypothesized that higher levels of physical activity after a breast cancer diagnosis would be associated with longer survival.”

Exercising Your Spiritual Muscle

From “Exercising My Spiritual Muscle” by Bill Bazan at www.medicineinsearchofmeaning.blogspot.com:

“I am a great believer that meaning and purpose will find me each and every day whenever I am ready to receive its message. No matter what challenges me, no matter what happens to me, and no matter what experiences I am currently engaged in… all events provide a scenario wherein meaning and purpose can be discovered, or better yet ‘uncovered.’ Allow me to share a story with you that you have probably heard many times over your lifetime. This story will illustrate clearly that it is not the experience itself that provides meaning and purpose, but what I am able to bring to that experience. In other words, what I bring to the table of my life today will determine how the day evolves, either enhancing a sense of meaning or diminishing my inner spirit.”

“He brought the boys to the classroom that the pony lived in. Looking through a window into the classroom, the first boy grimaced at what he saw. As this boy entered the classroom, he held his nose in disgust, and complained about the stench. After a few seconds the boy ran out of the room complaining about the experience. The second boy was led to the window. Looking in, this boy smiled from ear to ear. He couldn’t wait to enter the classroom. Upon entering the room, the boy walked around with an inquisitive look on his face. The teacher asked him if he had any questions. The boy responded with great enthusiasm: ‘Where’s the pony? Where there’s horse manure there must be a pony!’ The teacher wondered why the responses by the two boys to the same event were so different.”

For the “rest of the story” and related resources, go to www.medicineinsearchofmeaning.blogspot.com

Bill Bazan is a widely respected and long time friend of RWHC, first at the Wisconsin Catholic Health Association and then after he joined the Wisconsin Hospital Association in 1997 as Vice President for Metro Milwaukee, a position from which he “retired” in 2011. He is more active then ever helping provider networks implement his “Medicine in Search of Meaning” (MISM) Program. For more information about the MISM program, contact Bill at bbazan@wi.rr.com or 414-906-1832.

RWHC Corporate Partner: Legato Healthcare

RWHC is pleased to announce Legato Healthcare Marketing as its newest Corporate Partner.

Legato was selected for partnership based on its successes in helping rural hospitals throughout Wisconsin grow patient volumes, profits and market share in spite of the challenges posed by healthcare reform.

“Legato is well aware of the challenges posed by the Affordable Care Act, changing healthcare trends and proposed changes to CAH location requirements as
well as the other factors affecting the viability of rural healthcare organizations,” says Tim Size, Executive Director, Rural Wisconsin Health Cooperative. “They share our commitment to improving healthcare in rural America.”

Mike Milligan, President, Legato Healthcare Marketing says, “We're honored to be selected as an RWHC partner, and we look forward to helping the Cooperative's members overcome the distinct challenges they face, and leverage new opportunities for growth and success.”

Legato Healthcare Marketing is a healthcare marketing agency headquartered in Green Bay, Wisconsin. In addition to working with several RWHC Members, Legato provides specialized marketing solutions to rural health organizations, specialty clinics and medical equipment companies. For ongoing news, please visit: www.legatohealthcaremarketing.com.

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Leadership Insights: “What’s Your Problem?”

The following is from RWHC’s Leadership Insights newsletter by Jo Anne Preston, RWHC Organizational Development Manager. Go to www.RWHC.com for back issues.

“What’s your problem? This is a legitimate question (no tone of voice intended). Have you ever thought you solved a problem only to discover that your solution made a mess of things? Recalling our past problem solving blunders can remind us how important it is to take a few steps to understand what the real problem is before jumping to solutions. For example:

a) Problem: “We can’t get our work done!” Quick solution: just work harder, or hire more staff (only to find out they still can’t get all the work done because the real problem is unclear goals).

b) Problem: “The manager is unfair. I am putting in way more hours than the rest of the team.” Solution: Coach the manager to treat everyone fairly (what you don’t know is that the employee working all the extra hours can’t say no when asked to take co-worker’s shifts).

c) Problem: “We need more parking spaces. I can never find a spot!” Solution: You trust this person and take their comments at face value, so you send the message to administration that the parking lot needs to be reconfigured. (But does the data support this situation?)

“There are many tools available for problem solving; we cover lots of them in our team facilitation workshop. But even before you look at tools, consider how your personality and beliefs about what makes a successful leader influences your reaction when someone says to you, ‘I have a problem.’ Following are some underlying causes of poor problem solving, and some ideas to consider for improvements:

- **It feels good to have the answers.** “Immediately. Coming across as decisive and taking action is often equated with strong leadership, and we think it is quicker, so going right for a solution is tempting. There is definitely a time and a place for jumping to a fix, but be careful if this is your ‘go-to’ style. When someone comes to you with a problem, even if you think you understand it, just ask, ‘Can you tell me a little bit more about this?’ before offering your solutions. Then listen for more to the story. The parking lot example above was my own. Years ago I went to my manager stating that the parking lot was full and I could never find a place to park. She asked me to tell her more, and after a little bit of discussion, I had to admit that I actually *could* find a place to park but sometimes it took a while and was far away (poor me, right?). She could have just taken this problem on, taking my word for it and creating more work for her to have to follow up on.”

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Support NRHA Rural Leadership Development

The National Rural Health Association has launched a permanent endowment for programs that identify emerging leaders from and for rural communities. The mission is to provide training and resources to help them play a lead role in ensuring access to quality health care for rural Americans.

Go to [http://ow.ly/ejmLF](http://ow.ly/ejmLF) to learn more.
You want the very best possible solution. “The opposite of the previous strategy, you want to treat every problem to endless discussion and dissecting but this can use up precious resources unnecessarily. If you find that your desire for the ultimate is keeping you stuck, ask employees to come to you with their problems ‘pre-analyzed.’ You don’t have to be a six sigma black belt to use the simple tool called the 5 Whys available at http://ow.ly/pEvDF.

You want everyone to be happy. “This can lead to decisions driven by feelings, ignoring the facts. The heart needs to be heard for certain, but to get better outcomes, push yourself to look at the facts too. If keeping people happy keeps you up at night, make a list of the factors you would consider if no one cared about the outcome. Find a colleague who balances you and kick your problems around together. You can give them the more emotional perspective, and they can help you see the analytical perspective. Over time, this partnered mentoring trains you to look at problems in a different way.”

You want things done your way (the right way of course). “Do you get defensive when someone challenges your solutions? If so, it can lead to others not wanting to share different points of view with you. This limits creativity and keeps problems in the dark where they can fester. Pre-empt your own defensiveness by requesting that people poke holes in your answer. Ask, ‘What can go wrong with this solution?’ ‘What have I not thought about?’ ‘What would you do differently?’ By actively seeking this kind of feedback, it makes it safer for people to share and you prepare yourself for it. Remind yourself to keep an open mind. You may really learn something!”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For info re the RWHC Leadership Series 2013 go to www.RWHC.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.”