Rural Health and Critical Access Hospitals: Opportunities and Challenges

RWHC Eye On Health

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Outline of Talk

1. RWHC & Advocacy
2. Overview of Rural Health Care
3. Rural Health Care Means Rural Jobs
4. Critical Access Hospitals Here to Stay
5. Health Care ➔ Community Health
6. Today’s Challenges
7. Top 20 CAH Success Factors
8. Bottom Line Principles
1. RWHC & Rural Advocacy

RWHC is a collaboration of 40 rural hospitals located across the state. Mission of advocacy and shared services in support of keeping local care local.

The Rural Advocacy Agenda is Multifaceted

- Federal and market places reform that works for rural.
- Fair Medicare and Medicaid payments to rural providers.
- Federal and State regulations that recognize rural realities.
- Retain property tax exemption for nonprofit hospitals.
- Solve growing shortage of rural physicians and providers.
- Bring rural voice to regional provider networks & payers.
- Bring a rural voice into the quality improvement movement.
- Continue push for workplace and community wellness.
- Strong link between economic development and rural health.
Big Challenges Not New to Rural (1 of 2)

1970s: Federally funded planners proposed massive consolidation of rural hospitals in Wisconsin; that plan was blocked and RWHC’s role as an advocate was born.

1980s: Growth of health plans with closed provider networks were seen as threat; RWHC started a rural based plan and received federal anti-trust protection.

1980-90s: Medicare radically changed how they paid hospitals and 100’s of rural hospitals closed; in response, RWHC and others championed Medicare’s Critical Access Hospital program that provides critical support to most of our members today.

Meeting Big Challenges Not New (2 of 2)

• 1990s: Growth in the shortage of physicians working in rural Wisconsin has led to the Wisconsin Academy of Rural Medicine, RWHC’s Wisconsin Collaborative for Rural Graduate Medical Education and a major rural expansion by the Medical College of Wisconsin.

• 2000s: The National Institute of Medicine highlighted major gaps in American health care quality—RWHC helps lead call for rural relevant metrics.

• 2010s: That providers will be paid not for volume but for value has led RWHC to focus on services preparing for the new era of Accountable Care Organizations.
2. Overview of Rural Health Care

There is an Ongoing Need for Rural “Myth” Busting

- Rural residents don’t care about local care.
- Rural folks are naturally healthy, need less.
- Rural health care costs less than urban care.
- Or rural health care is inordinately expensive.
- Rural quality is lower; urban is better.
- Rural hospitals are just band-aid stations.
- Rural hospitals are poorly managed and governed.

Rural Health Typically Does More With Less

- “The people served by rural hospitals are more likely to report a fair to poor health status, suffer from chronic diseases, lack health insurance, and be heavier, older, and poorer than residents of urban areas.”
- Yet overall, the average cost per Medicare beneficiary is 3.7 percent lower in rural communities than in urban ones, and rural hospitals perform better than urban hospitals on three out of the four cost and price efficiency measures on Medicare Cost Reports.”

“Implications of Proposed Changes to Rural Hospital Payment Designations Policy Brief,” by The National Advisory Committee on Rural Health and Human Services, December, 2012
However, in recent years, the majority of the enrollment in PFFS plans has shifted to PPO plans in rural areas. The ACA created quality-based bonus payments for MA plans with ratings of 4.0 stars or higher. Using this rating level as a dividing line, a higher proportion of urban MA enrollees (36.0% compared to 31.6% in rural areas) are enrolled in an MA plan that receives a bonus payment. However, nearly all MA enrollees both in rural areas (91.9%) and in urban areas (94.4%) are in plans with a quality rating of 3.0 stars or higher (Figure 2), qualifying them for bonus payments under the current demonstration program. Nearly one-half (49.8%) of rural HMO enrollment is in a plan with a 4.0-5 star or higher rating, while only 24.7% of rural PPO enrollment is in such a plan. The majority (73.6%) of rural PPO enrollment is in plans with an average quality rating of 3 or 3.5 stars. Many rural Medicare beneficiaries have limited access to MA plans and in some areas do not have an HMO option available to them, leaving them with PPO plans as their only option.

Figure 2. Percentage of Plans and Enrollment by MA Plan Star Rating and Location, 2012

The quality rating of rural MA plans varies significantly across the country, with the highest quality ratings in rural areas in Minnesota, Iowa, Wisconsin, Oregon, Pennsylvania, and Maine (Figure 3). MA beneficiaries in southern and some central midwestern rural areas are, in general, enrolled in MA plans with lower quality.
3. Rural Health Care Means Rural Jobs

Rural health is about rural health and health care but it is also about the whole community, especially jobs & vice versa.

Rural Health is an Export “Commodity”

- People often know that business relocation decisions are influenced by the cost and quality of health care available locally.

- But 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 the community.
Jobs in All Sectors Depend on Rural Health

- **Rural insurance premiums and taxes only come back** to the community and create jobs if **there are local health care providers** there (and people use them) to attract those dollars.

- For **every 2 rural health jobs created** (or lost), the number of **other community jobs** increase (or decrease) by **1+ jobs**.

- **The rural economy is very dependent on where its health care dollars are spent.**

4. Critical Access Hospitals Here to Stay

**Most rural hospitals are CAHs**, a distinct Medicare provider type with a cost based payment method. **CAHs basically same as PPS**, except have 25 bed max. and average 96 hr. LOS max.

MASH = Mobile Army Surgical Hospitals
Wisconsin’s Snap Shot as a National Leader

- **13 CAHs in iVantage top 100 CAH List (2013)**
  (Including Door County Medical Center)
- Relatively **high overall quality** in national studies
- Relatively **low rate of uninsured**
- Relatively **low Medicare costs**
- Relatively **strong physician/hospital cooperation**
- Relatively **more stable provider finances**
- **Robust adoption of HIT**, especially with EHR
- **Supportive tort environment**
- **Many early adopters of population health**
5. Long Term: Health Care ➔ Community Health

It’s not longer just about what we charge for a hospital visit but **what it costs to keep a population healthy.**

“We must help all reach **highest potential for health** and reverse the trend of **avoidable illness.**”*


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**County Health Outcome Rankings – 2014**

**Door County**

**Health Outcomes: 5th**
Morbidity: 4th
Mortality: 13th

**Health Factors: 20th**
Social/Economic: 37th
Behaviors: 16th
Clinical Care: 14th
Environment: 4th
6. Today’s Challenges

Rural Health faces an alignment of forces driving reform to improve individual health care, the health of populations and lower costs (Known as the “Triple Aim”).
Details Differ: Big Picture Unchanged

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<tr>
<th>Current State</th>
<th>Future State</th>
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<tr>
<td>Cost:</td>
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<td>Reduction Viewed as Discrete Projects</td>
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<td>Quality:</td>
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<td>Public Relations/Liability Issue</td>
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<td>Physicians:</td>
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<td>Drive Volume</td>
<td>Drive Value</td>
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<td>Collaboration:</td>
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<td>Limited Amount Required for Financial Success</td>
<td>Clinical and Finance Staff Must Work Together</td>
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<td>Financial Risk:</td>
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<td>Revolves Around Cost Position</td>
<td>Revolves Around Utilization of Services Across Continuum</td>
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Healthcare Financial Management Association

The Four Questions Facing Every Hospital

1. How do we provide **local patient-centered care** that is team based and outcome focused?

2. How do we **collaborate** with regional organizations to **emphasize value of care over volume of care**?

3. How do we **partner** with others locally and regionally to **foster healthy communities**?

4. How do we **adapt urban-based federal models** to the unique characteristics of our rural communities?
7. Top Twenty CAH Critical Success Factors

Top Twenty CAH Critical Success Factors

**Leadership**
1. Engage & educate the hospital board
2. Align hospital leaders & managers
3. Unite with physicians & other 1° care providers

**Strategic Planning**
4. Do meaningful strategic planning at least annually
5. Use a systems framework for planning to ensure a holistic approach
6. Communicate the plan organization-wide in easy to understand language

Terry Hill, Executive Director
National Rural Health Resource Center

Albert Einstein said “Insanity is doing the same thing over and over again and expecting different results.”
Top 20 CAH Success Factors

**Patients, Partners & Communities**

7. Measure and **publicly report patient satisfaction**
8. **Explore partnerships** with rural network and/or larger systems
9. Explore partnerships with **other providers in your service area**
10. **Engage & educate your community**

Terry Hill, Executive Director
National Rural Health Resource Center

Top 20 CAH Critical Success Factors

**Measurement, Feedback, & Knowledge Management**

11. Use a **strategic framework to manage information**
12. Evaluate strategic process regularly and **share information organization-wide**
13. Gather & **use data to improve health and safety of patients in the service area**

Terry Hill, Executive Director
National Rural Health Resource Center
Top 20 CAH Critical Success Factors

Workforce & Culture

14. Develop a **workforce** that is **change ready** and customer / **patient focused**
15. **Focus** intensely on **staff development and retention**

Operations & Processes

16. Develop **efficient business processes** and maximizes revenue cycle management
17. **Continually improve quality** and safety processes
18. **Use technology appropriately** to improve efficiency and quality

Terry Hill, Executive Director
National Rural Health Resource Center

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Impact & Outcomes

19. **Publically report** and communicates **outcomes**
20. **Document value** in terms of **cost, efficiency, quality, satisfaction, and population health**

Terry Hill, Executive Director
National Rural Health Resource Center
Bottom Line Principles

RWHC Eye On Health

“When the obvious becomes obvious, the time to adjust is limited.”

Health is More Than Health Care

RWHC Eye On Health

“Get over the Doc Welby thing, what you do makes a lot more difference to your health than what I do.”
Vision Matters

“Rural Health and Critical Access Hospitals: Opportunities and Challenges”
Ministry Door County Medical Center, Sturgeon Bay, WI, April 14th, 2014

“..." (Yogi Berra)
Cooperate In Order to Successfully Compete

RWHC Eye On Health

“I like it, but ‘Thou Shall Not Fail To Cooperate When Resources Are Scarcely’ makes eleven.”

Rural Health Resources

- **RWHC Web**: [www.RWHC.com](http://www.RWHC.com)
- **Free RWHC Eye on Health e-newsletter**: Email office@rwhc.com with “subscribe” on subject line.
- **Wisconsin Office of Rural Health**: [http://WORH.org](http://WORH.org)
- **County Health Rankings & Roadmaps**: [www.countyhealthrankings.org](http://www.countyhealthrankings.org)
- **Nation Rural Health Resource Center**: [www.ruralcenter.org](http://www.ruralcenter.org)
- **Rural Assistance Center** at [www.raonline.org/](http://www.raonline.org/) is an incredible federally supported information resource.