Belief: Spring Will Follow a Lousy Winter

- 1970s: Regional planners propose consolidation of rural hospitals ➔ blocked; RWHC born as advocate.
- 1980s: HMO explosion with closed networks seen as threat ➔ RWHC starts HMO; Fed anti-trust protection.
- 1980-90s: Shift to PPS closes 100s of rural hospitals ➔ birth of CAHs in 1997.
- 1990s to Today: Growth of MD Maldistribution ➔ WARM, WCRGME & MCW expansion plans.
- 2000: IOM Reports poor quality of all hospitals ➔ Triple Aim of better health and care at lower cost.
Presentation Overview

I. Brief Intro to RWHC
II. Overview of Rural Health As Now Is
III. Critical Access Hospital Fundamentals
IV. Current Wave of Challenges (Partial List)
V. Rural Advocacy: Make the Invisible Visible
VI. 30+ Minutes for Discussion/Rebuttal

*Please feel free to speak up at anytime.*

I. Brief Intro to RWHC

RWHC has a long tradition of being entrepreneurial, collaborative and data driven. But above all, our focus has always been to support and speak up for rural hospitals.
RWHC Mission, Vision & Structure

**Mission:** Rural WI communities will be the healthiest in America.

**Vision:** RWHC is a strong and innovative cooperative of diversified rural hospitals; it is (1) the “rural advocate of choice” for its Members and (2) develops and manages a variety of products and services.

Synergy Between Advocacy & Service

RWHC Services Support Advocacy Role:

- External Credibility
- Similar Infrastructure
- Profits Subsidize Advocacy
- Inform Advocacy; Early Warning Sign for Issues
- Advocacy Needed Not Just with Government but in Marketplace and with Academe
RWHC at 10,000 Feet

- Founded in 1979.
- RWHC is Non-profit coop owned by 37 rural hospitals (with net rev ≈ $1.4B & 2,000 hospital & LTC beds).
- 8 PPS & 29 CAH; ≈ 23 freestanding and 14 system affiliated.
- ≈ 70 employees (≈ 50 FTE).
- ≈ $11M RWHC budget (75% member sales, 17% non-member sales, 6% dues & 2% grants).

RWHC Shared Services*

**Professional Services**
- Financial & Legal Services
- Coding Audits/Review

**Educational Services**
- Professional Roundtables & Leadership Training
- Nurse Residency Program & Preceptor Workshops
- Lean Lab (with Lean Six Sigma Master Black Belt)

**Quality Programs**
- Credentials Verification Organization (NCQA Certified)
- Quality Indicators Reporting (The Joint Commission Approved)
- Patient Satisfaction Surveys (CMS approved vendor)

**Technology Services**
- Data Center Services
- Electronic Medical Records & Technology Management

* Partial List
RWHC’s Rural Agenda is Multifaceted

- Federal healthcare reform that recognizes rural realities.
- 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.

RWHC Focus on Strategic Partnerships

- Cooperative Network
- Federal Office of Rural Health Policy
- La Crosse Med. Health Science Consort.
- Marquette University
- Medical College of WI
- MetaStar, Inc.
- National Cooperative of Health Networks
- National Rural Health Resource Center
- National Rural Health Association
- UW School of Medicine & Public Health
- UW School of Nursing
- UW School of Pharmacy
- WI Area Health Education Centers
- WI Center for Nursing
- WI Collaborative for Healthcare Quality
- WI Council on Workforce Investment
- WI Dept of Health Services
- WI Dept of Workforce Development
- WI Dept Safety & Professional Services
- WI Hospital Association
- WI Health & Ed. Facilities Authority
- WI Healthcare Data Collaborative
- WI Medical Society
- WI Office Rural Health
- WI Primary Care Association
- WI Public Health Association
- WI Rural Health Development Council
- WI Statewide Health Info. Network
II. Overview of Rural Health As Now Is

_Please refer to page 11 for the content._

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U.S. Hospitals

_Please refer to page 11 for the content._
Rural Hospitals: Backbone of Rural Health
North Carolina Health Research Policy Analysis Center, 8/12

1,327 CAHs as of 6/30/12
Rural Hospitals Have a Lot to Brag About

- Rural hospital performance on CMS Process of Care measures is on par with urban hospitals.
- Rural hospital performance on CMS Outcomes measures is better than urban hospitals.
- Rural hospital performance on HCAHPS inpatient experience survey measures is better than urban hospitals.
- Rural hospital performance on price and cost efficiency measures is better than urban hospitals.
- While, Medicare spent $2.2 billion less in 2010 on rural beneficiaries—3.7% less than average urban beneficiary.

“Rural Relevance Under Healthcare Reform” (based on Medicare Shared Savings Data Files) 1/23/12
http://www.ivantagehealth.com/

Rural in Upper Midwest Is a Relatively Low Cost Region

Daily Yonder & Dartmouth Health Atlas, 10/09
Urban & Rural WI Hospitals Are Leaders

- 13 CAHs in iVantage top 100 CAH List (2013); (including Door County & Merrill from Ministry)
- High overall quality (2nd in 2011 - AHRQ)
- Low rate of uninsured (tied for 5th in 2010-11)
- Low cost state in Medicare program
- Relatively strong physician/hospital cooperation
- Hospitals’/systems’ relatively better finances
- Robust adoption of HIT, especially with EHR
- Supportive tort environment
- Leadership promoting county health rankings

iVantage Hospital Strength List: Top 100 CAHs

Comprehensive scorecard that evaluates: market conditions, clinical and operational performance, and financial and qualitative outcomes; sample of findings:

- Top 100 CAHs perform as well or better than median overall of all U.S. general acute care hospitals
- Top 100 CAHs quality is near the Top Quartile when compared to all U.S. general acute care hospitals
- Top 100 CAH Financial and Cost & Charge performance is in the Top Quartile of all hospitals.
- Top 100 CAHs have diverse organizational structure – (52% are independent; 48% are system-affiliated).
Overview of Rural Hospital Services

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Urban % of hospitals in 2010</th>
<th>Rural % of hospitals in 2010</th>
<th>Percentage point change 2005-2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>High-tech services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robotic surgery</td>
<td>36% 22</td>
<td>2% 1</td>
<td></td>
</tr>
<tr>
<td>PET or PET/CT scanner</td>
<td>60 10</td>
<td>16 4</td>
<td></td>
</tr>
<tr>
<td>MRI</td>
<td>93 3</td>
<td>85 9</td>
<td></td>
</tr>
<tr>
<td>Core services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative care</td>
<td>54 9</td>
<td>22 2</td>
<td></td>
</tr>
<tr>
<td>Indigent care clinic</td>
<td>37 9</td>
<td>11 4</td>
<td></td>
</tr>
<tr>
<td>Orthopedics</td>
<td>87 5</td>
<td>60 8</td>
<td></td>
</tr>
<tr>
<td>Open heart surgery</td>
<td>48 5</td>
<td>4 1</td>
<td></td>
</tr>
<tr>
<td>Cardiac catheterization</td>
<td>63 4</td>
<td>7 0</td>
<td></td>
</tr>
<tr>
<td>Oncology</td>
<td>76 1</td>
<td>39 2</td>
<td></td>
</tr>
<tr>
<td>Geriatrics</td>
<td>53 1</td>
<td>32 –1</td>
<td></td>
</tr>
<tr>
<td>Trauma center</td>
<td>46 1</td>
<td>37 4</td>
<td></td>
</tr>
<tr>
<td>Post-acute services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing</td>
<td>35 –6</td>
<td>43 –3</td>
<td></td>
</tr>
<tr>
<td>Home health</td>
<td>61 –3</td>
<td>56 –5</td>
<td></td>
</tr>
</tbody>
</table>

Note: Extremely large and small values excluded from display. Source: Analysis of Medicare Cost Reports by NC RHRC.
USA Less Rural & Rural Farms Less

Population by Rural and Farm Residence, Wisconsin: 1850 to 2000

Gary Paul Green, UW-Madison/Extension
Presentation in Mosinee, 1/12-13/06

Rural Health’s Two-fer: Health & Jobs

Rural health is all about the natural tension between the power of capital and the power of place.

This makes rural health dependent on the local community, local employers, local schools & vice versa.
Jobs Depend on Rural Health (1 of 2)

- Local rural health = local health care jobs.
- People often know that business relocation decisions are influenced by the cost and quality of health care available locally.
- But as or more importantly, rural health has the same economic impact as export commodities like milk, soy beans or rural based manufactured goods because of its ability to bring dollars and jobs into the community.

Jobs Depend on Rural Health (2 of 2)

- 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 2 jobs created (or lost) in rural health care, the number of jobs in other local businesses increase (or decrease) by 1+ jobs.
- The rural economy is extremely dependent on WHERE its health care dollars are spent.
As part of the Triple Aim, rural providers increasingly looking at both individual healthcare and ways to improve the overall health of their community.

2012 Wisconsin County Health Rankings Model, University of Wisconsin Population Health Institute
Rural Wisconsin Faces Significant Challenges

The state dental association and tavern league may look at these maps differently.
III. Critical Access Hospital Fundamentals

CAHs are a distinct Medicare provider type with a cost based payment method. Conditions of Participation basically same except: 25 bed max. and average 96 hr. LOS max.

Rural Hospitals 1946-97 (1 of 2)

1946 The Hill–Burton Act financed the vast majority of hospitals built in rural America following World War II.

1965 “Medicare established, adopting the private health insurance sector’s ‘retrospective cost-based reimbursement’ system to pay for hospital services.”

1982 “Congress mandated the creation of a prospective payment system (PPS) to control costs—a per-case reimbursement mechanism called diagnosis-related groups (DRGs). In this DRG prospective payment system, Medicare pays hospitals a flat rate per case for inpatient hospital care so that ‘efficient’ hospitals are rewarded.”

Office of Inspector General, 8/01
Rural Hospitals 1946-97 (2 of 2)

In 1988 "Montana Hospital Research and Education Foundation designed a demonstration of a hospital called a Medical Assistance Facility (MAF) that received cost-based reimbursement from Medicare. MAFs were isolated, limited-service hospitals that could admit patients for no more than a four-day length of stay. In 1989 Congress authorized the Rural Primary Care Hospital (RPCH) program, a second demonstration program for small, rural hospitals would receive cost-based payments from Medicare. 1997, Balanced Budget Act of 1997 merged the MAF and RPCH programs into Critical Access Hospitals (15 acute bed limit)."  

Change for CAHs Is Not New

- Balanced Budget Act (BBA), ‘97
- Balanced Budget Refinement Act (BBRA), ‘99
- Benefits Improvement and Protection Act (BIPA), ‘00
- Medicare Prescription Drug, Improvement, and Modernization Act (MMA), ‘03
- The Medicare Improvements to the Patients and Providers Act, ‘08
- Conrad Improvement Act, ‘08
- Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, ‘08
- American Recovery and Reinvestment Act (ARRA), ‘09

http://www.aha.org/
Startup: Balanced Budget Act (BBA), ’97

- CAHs receive reimbursement of “reasonable” costs.
- CAHs must be located in a rural area > 35 mile distance from another hospital, or 15 miles in mountainous terrain or with only secondary roads except for state designated “necessary providers.”
- Must restrict patient length of stay to no more than 96 hours unless waived for an emergency.
- Must have 15 or fewer acute inpatient care beds (or, in the case of swing bed facilities, up to 25 beds).
- Must offer 24-hour emergency services.
- Must be owned by a public or nonprofit entity.

http://www.aha.org/

Major Improvements with BBRA, ’99

- Replaced 96 hour LOS limitation per patient with an annual average.
- Permitted CAHs to bill at the all-inclusive rate or continue to bill hospital and physician services separately.
- Granted CAH status to hospitals that have closed in the past 10 years or downsized to a health clinic or center.
- Allowed CAHs to continue providing long-term care services via the swing bed program and not under PPS.
- Extended CAH eligibility to for-profit hospitals.

http://www.aha.org/
Big Gains & Tradeoffs with MMA, ’03

- **Flexibility for 25 beds as acute care inpatient beds.**
- Increase CAH reimbursement to cost plus 1%.
- Provide cost-based reimbursement for certain emergency room staff who are on-call.
- Reinstate the Periodic Interim Payments (PIPs).
- Expand by 15% billing for outpatient services to any practitioner who assigns billing to CAH.
- Permit CAHs to operate Psychiatric and/or Rehabilitation (DPUs) of up to 10 beds.
- **State authority to waive 35-mile rule ends 1/06.**

http://www.raonline.org/

“Rest of the Story”-Advocacy (1 of 4)

1983 Medicare payment equity issues led to rural hospitals seeing that they had unique set issues.

1985 NRHA and Rural Wisconsin Hospital Cooperative (RWHC) “challenged the justice of a system based on rates perpetuating historical urban and rural payment inequities not related to legitimate wage or intensity differentials.” We demanded the development of a model more sensitive to actual labor markets than one where the wage scale takes a nose dive at the urban county line.

"A Pause On The Road To Rural Hospital Equity"
National Rural Health Association, Newsletter, Oct-Dec 1992
“Rest of the Story” (2 of 4)

1987 In good part fueled by the equity issue, the National Rural Primary Care Association and American Small and Rural Hospital Association merge to form the National Rural Health Association (NRHA), creating a “new unified voice for rural health.”

1987 NRHA develops a class-action suit advocated by RWHC against the Department of Health and Human Services for a constitutional “unjust taking of property” due to a failure to provide just compensation to rural hospitals for services to Medicare patients.

“Rest of the Story” (3 of 4)

1988 The Dartmouth Atlas of Health Care: “The reality of health care in the United States is that geography is destiny. The amount of care consumed by Americans depends more on where they live—the local supply of resources and the prevailing practice style—than on their needs or preferences.”

1998 In a Budget Resolution, the United States Senate recognized that while “all Americans pay the same payroll tax of 2.9 percent to the Medicare trust funds and deserve the same choices and services regardless of where they retire, some regions receive 2.5 times more in Medicare reimbursements than others.”
“Rest of the Story” (4 of 4)

2000 RWHC Business Cards: “Medicare spending in Wisconsin per beneficiary was 7th from the bottom—$4,319 in Wisconsin vs. $5,541 nationally. Wisconsin is penalized for our more efficient provider systems and for ongoing inequitable federal payment policies, particularly the application of technically flawed adjustments for regional wage differences.”

2003 “I will insist our rural policies be conferenced first.” Opening Floor Statement of U.S. Sen. Chuck Grassley of Iowa, Chairman, Senate Committee on Finance, 6/17/03. Paul Ryan CAH advocate in House.

The Downside for CAHs – (1 of 5)

Cost reimbursement is a blessing and a curse – “You don’t lose money on Medicare services, but…

(1) you also do not make money (even considering the current 1% over Medicare cost), so there is no contribution to margin. The more Medicare business that you have, the harder it becomes to generate operating margin.”

(2) Providing non-hospital services is a challenge due to their absorption of overhead costs required by Medicare cost accounting.

Rich Donkle, RWHC Director of Financial Consulting Services
The Downside for CAHs – (2 of 5)

Operating within regulatory constraints – “The 25 bed limit can present a challenge if a variety of patients are served, such as OB, ICU, surgical and medical. The uncertainty that accompanies the relocation of a CAH (not knowing for certain that you will maintain status until after the relocation is complete).

In addition, CMS seems to always come up with new ways to complicate operating as a CAH (physician supervision requirements for example).”

Rich Donkle, RWHC Director of Financial Consulting Services

The Downside for CAHs – (3 of 5)

Non-acute services absorb disproportionate amount of costs – “Medicare uses full absorption cost accounting, not discrete or incremental costing, so non-hospital services are allocated overhead costs in the same manner as if they were hospital services.

As noted earlier, this makes the provision of services such as SNF, assisted living, and even a home meals program a challenge to provide under the umbrella of the hospital corporation.”

Rich Donkle, RWHC Director of Financial Consulting Services
The Downside for CAHs – (4 of 5)

**Maximizing cost reimbursement can bring unintended consequences** – “Maximizing Medicare cost reimbursement means minimizing non-Medicare cost reimbursed services. OB, Psych, SNF and other non-hospital services are all ‘losers’ when it comes to cost reimbursement.

Even increasing non-Medicare acute hospital patient days can have a detrimental impact on Medicare cost reimbursement.”

Rich Donkle, RWHC Director of Financial Consulting Services

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The Downside for CAHs – (5 of 5)

**Impact of Medicare Advantage Plans** – “Currently, Medicare Advantage Plans reimburse at levels equivalent to regular Medicare, but without an actual cost settlement. **Cost reimbursement, or its proxy, can be more costly for MA Plans, so they may have an incentive to try to have patients treated elsewhere.**

They have to balance cost with keeping patients in their plan, but can be a threat to a CAH with a lot of Medicare Advantage Plan patients in their service area.”

Rich Donkle, RWHC Director of Financial Consulting Service
IV. Current Wave of Challenges (Partial List)

Rural Health is not exempt from political chaos and the alignment of forces driving reform to improving population health, individual health care, and lower costs (the Triple Aim).

Medicaid: Building on Governor’s Proposal

- **Governor’s initial plan will cost WI taxpayers an additional $63 Million** over next 3 years with **9,000 fewer Medicaid enrollees**. Gives up $910 Million in Federal Medicaid funding to State over 3 years.

- **The proposed plan** depends on the Exchange start-up working for 180,000 low income people (vs. 55,000 for 133% FPL option) → **high risk of uncompensated care**.

- **Coverage to 133% FPL will save WI taxpayers up to $147 Million** over next 3 years and allows for **117,000 more Medicaid enrollees**. Brings additional $1 Billion in Federal Medicaid funding to State over 3 years.
Critical Access Hospital Medicare Cuts?

- Sequestration - 2% cut to all rural hospitals (President's budget)
- Elimination of CAH status for nearly 50 hospitals (President's budget)
- Proposed cuts in Flex and outreach grants
- Proposal to eliminate all CAHs (CBO budget proposal)
- 35% cut uncompensated care
- Provider tax (assessment) cuts

Source: NRHA

Rural PPS Hospital Medicare Cuts?

- MDH expiration - 12% inpatient cut to 200 rural hospitals
- LVH expiration - 13% inpatient cut to 650 rural hospitals
- Sequestration - 2% cut to all rural hospitals
- 25% cut in DSH payments to rural hospitals (Non-CAH)
- Hold harmless - 4% cut in outpatient payments
- 5% cut uncompensated care to rural hospitals (Non-CAH)
- Coding and documentation cuts

Source: NRHA
Public & Private Sector Market Reform (1 of 2)

Goal: Decrease Uninsured and decrease costs will:

- Increase market share in public and private exchanges: think booking a hotel on Expedia or an airplane ticket on Kayak versus using a travel agent.
- Cause health plans to design products to attract and care for healthy people.
- See growth in tiered health plans that give people an incentive to go to hospitals that provide overall quality care at the lowest cost (example: United).

Public & Private Sector Market Reform (2 of 2)

Insurer financial success in exchanges depends on:

- Create products that attract healthy people (*rural disadvantage as healthier people may be incented to migrate to plans in urban/suburban markets?*)
- Adequate risk adjustment to fairly compensate health plans with higher risk patients (*will Feds adequately protect rural markets with older, sicker patients; indirect continuation shift of funds to FLA, CA & NY?*)
- Manage chronic conditions better than other health care organizations (*do rural have the resources to do as aggressively as will be needed?*)
“By 2020, our nation will face a serious shortage of both primary care and specialist physicians. The shortfall will be most severe on vulnerable and underserved populations. Unless we act now, America will face a shortage of more than 90,000 doctors in 10 years.”

-- Association of American Medical Colleges
June 2010

“Wisconsin will need to add 100 new physicians annually to avoid an expected shortfall of 2,000 by 2030. The need is most urgent in primary care, general surgery and psychiatry – in both rural and underserved urban areas.”

-- Wisconsin Hospital Association
November 2011

“If students complete both their medical education and residency training in Wisconsin, nearly 70% will remain in the state to practice medicine.”

-- AAMC State Physician Workforce Data Book
December 2011

* The green shaded areas denote federally-designated rural and urban locations where there are significant shortages of primary care physicians


**PROJECTED NEED FOR PHYSICIANS**

**UW Earlier Stepped Up Re Rural MDs**

<table>
<thead>
<tr>
<th>AHEC</th>
<th>WARM: WI Academy for Rural Medicine</th>
<th>WORH/GME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare elementary/high school students in basic science and expose to role models</td>
<td>Recruit students with rural background and career goals</td>
<td>Locate education and training programs in rural areas of WI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use rural appropriate curriculum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Facilitate graduates seeking training and employment in rural WI</td>
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<tr>
<td></td>
<td></td>
<td>Grow rural WI health care workforce</td>
</tr>
</tbody>
</table>

**Wisconsin Rural Pipeline** (adapted from recent IOM report)
From talk by Dean Robert Golden to RWHC Board, 2/1/13

RWHC, 880 Independence Lane, Sauk City, WI 53583  
(T) 608-643-2343  
Email: timsize@rwhc.com  
World Wide Web Site: www.rwhc.com  
Tweet: www.twitter.com/RWHC  
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WARM Regional & Rural Sites ➔ Rural GME?

MCW TIMELINE: PROGRAM DEVELOPMENT

2011
Conversations, Outreach, and Relationship building with Health System and Academic Partners
Interviews with National Programs
Focus groups with MCW Board, Faculty Students, and Staff

2012
Developed Initial Program Vision and Conducted Feasibility Study
Issued Call for Partners
Selected Regional Partners and Campus sites based on proposals and site visits
Launched Strategies to Maintain Community Engagement

2013
Campus Dean Recruitment
Development of Community Advisory Board
Submit LCME Application
Program Evaluation

2014
Student recruitment
Faculty development

2015
Matriculation of first class of students

2018
First class graduates and enters residency
Rural GME Choke Point in Physician Supply

Wisconsin Collaborative for Rural Graduate Medical Education Partnership with Wisconsin Rural Physician Residency Assistance Program

Funded by the CAH Assessment & Opportunity for UWSMPH and/or other potential sponsoring institutions.

Healthcare Reform ≠ Health Reform

“We must provide education and preventive care, help all reach highest potential for health and reverse the trend of avoidable illness. Individuals must achieve healthier lifestyles; take responsibility for health behaviors and choices... and act.”

Future: Healthy People / Healthy Communities

- Providers and patients need to connect to community health resources to improve individual health.
- Providers and the community need to “go upstream” to address factors that influence population health.
- In concert with clinical quality and efficiency metrics, rural communities need to employ metrics that assess these more global outcomes.
- Rural providers and their communities need to partner in creating healthier communities.

"The High Performance Rural Health Care System of the Future," RUPRI Health Panel, 9/2/11

Too Many Parents Believe in Herd Immunity

- Dean & Unity Health admin. data showed that for 2010 the combined Childhood Immunization Status rate for children age two in urban Dane County was 77% and the average in the rural counties studied was 66%. The HEDIS benchmark for 90% percentile is a rate of 89%.
- There are many immunization collaboratives in Wisconsin, some serving a single county, others more, all promoting immunizations.
- RWHC started SWIC with belief that sharing of best practices will greatly support increased immunization rates.
Promoting Advanced Directives (1 of 2)

**Wisconsin Medical Society takes up variation on theme championed early by Gundersen Lutheran**

- A shared approach, including pilot projects.
- A shared language around advance care planning.
- Share lessons.
- Not compete around advance care planning.
- Ask for broad base to contribute financially.

Promoting Advanced Directives (2 of 2)

- Advance care planning as a process of planning and communication, with conversation at its core
- **Facilitated advance care planning conversations a routine part of health care for all capable adults**
- Working with people of all backgrounds, faiths, cultures and identities to create an environment in which the conversation is normalized and thrives
- Ensuring that advance care planning documents are properly stored and retrievable in the medical record across health care settings
Future: Competition & Cooperation Coexist

“Like it, but ‘Thou Shall Not Fail To Cooperate When Resources Are Scarce’ makes eleven.”

V. Rural Advocacy: Make the Invisible Visible

Government and organizations driving policy are usually urban based, much of rural advocacy is dealing with myths. But our incredibly dysfunctional government also brings increasing challenge of not being collateral damage.
The Obvious: Politics Trump Policy & Research

Both public and private policy makers have constituencies that drive the process more than the best data or policy.

Elected & Appointed Officials Can Be At Odds

“No need to rebuild old rural hospitals when we have perfectly good Army surplus MASH tents.”
Tradition Conceals Important Questions

“The Future of Rural Health & Critical Access”
Tim Size, Ministry Health Care Hospital Leadership, 4/8/13

RWHC, 880 Independence Lane, Sauk City, WI 53583   (T) 608-643-2343
Email: timsize@rwhc.com  World Wide Web Site: www.rwhc.com  Tweet: www.twitter.com/RWHC   Page 33
Fear Often Trumps Hope & Delays Change

Machiavelli & Thomas Jefferson both understood that change required “that the hope of gain be greater than the fear of loss.”

Don’t Underestimate Economic Self Interest

“That’s where you’re wrong, we are businessmen first, dentists second.”
Bottom Line: Look at Rural Systemically

“Closing rural hospitals is great reform if you want costs to go up, access for care to decrease, hurt local economies and lose your physicians.”

Rural Health Resources

• RWHC Web: http://www.rwhc.com/
• Wisconsin Office of Rural Health: http://worh.org/
• For the free RWHC Eye on Health e-newsletter, email office@rwhc.com with “subscribe” on subject line.
• Rural Assistance Center at www.raonline.org/ is an incredible federally supported information resource.
• The Health Workforce Information Center is RAC’s new “sister” for health workforce programs, funding, data, research & policy www.healthworkforceinfo.org/
• Wisconsin State Journal Special Report: Rural Health: http://host.madison.com/special-section/rural_health/