

Review & Commentary on Health Policy Issues for a Rural Perspective – April 1st, 2004

RWHC Honors Rural Health Ambassadors

“Servant-Leadership is a practical philosophy which supports people who choose to serve first, and then lead as a way of expanding service to individuals and institutions. Servant-leaders may or may not hold formal leadership positions. Servant-leadership encourages collaboration, trust, foresight, listening, and the ethical use of power and empowerment.”

“The servant-leader is servant first, beginning with the natural feeling that one wants to serve, to serve first. Then conscious choice brings one to aspire to lead. He or she is sharply different from the person who is leader first. The leader-first and the servant-first are two extreme types. Between them there are shadings and blends that are part of the infinite variety of human nature.” (Servant As Leader by Robert Greenleaf.)

The Rural Health Ambassador Award was established to recognize “servant leaders” at member hospitals who go “beyond the call of duty” to promote the hospital and local community health care. Examples of such service include:

- Serving as the hospital representative on community boards/service organizations
- Representing the hospital through public speaking
- Participating in hospital events (health fairs, outreach activities, etc.)
- Supporting community health activities beyond the scope of the hospital

Recipients of the RWHC 2004 Rural Health Ambassador Award are:

- St. Clare Hospital & Health Services, Baraboo, **Lois Luethy**
- Columbus Community Hospital, **Darlene Marks**
- Upland Hills Health, Dodgeville, **Linda Griffiths**
- St. Joseph’s Community Health Services, Hillsboro, **Terry Sosinsky**
- Memorial Health Center, Medford, **Nancy Di Legge**
- The Monroe Clinic, **Onalee Marx**
- Memorial Medical Center, Neillsville, **Timothy Meyer**
- Southwest Health Center, Platteville, **Joan Bahr**



“In our interrelated society, itself part of an uncompromising interdependent world, we have to think about the whole complexity in order to act relevantly on any part of it.” Harlan Cleveland in “Knowledge Executive”

- Divine Savior Healthcare, Portage, **Lynn Martin**
- Sauk Prairie Memorial Hospital, Prairie du Sac, **David Eberdt**
- Reedsburg Area Medical Center, **Pat Roloff**
- The Richland Hospital, Richland Center, **Chris Drea**
- Ripon Medical Center, **Colleen Dolata**
- Stoughton Hospital, **Mary Quisenberry**
- Door County Memorial Hospital, Sturgeon Bay, **Katie Graf**
- Tomah Memorial Hospital, **Tracy Myhre**
- Vernon Memorial Healthcare, Viroqua, **Donna Nelson**
- Tri-County Memorial Hospital, Whitehall, **Kathy Kulig**

Managed Care: Nightmare or Opportunity?

From “The One Choice We Don’t Have Is Not Choosing—Medicare Managed Care: Nightmare or Opportunity?” by Tim Size in *Rural Health FYI*, 9/97:

“A prime example of the expansion of market oriented methods is the clear movement of both Medicaid and Medicare to encourage the greater use of competitive models such as HMOs and medical savings accounts. In the face of this reality, NRHA has for some time expanded its fight for Medicare payment equity to Medicare managed care plans. Through the efforts of advocates within and outside of Congress, the recently passed Balanced Budget Act of 1997 substantially reduces the variation in payment rates to HMOs for Medicare beneficiaries.”

“While this remarkable policy victory has the potential to allow for more equitable reimbursement to rural providers, it does not guarantee it. Like the introduction of WalMart throughout rural Wisconsin, it

will be seen very differently by different people—by some a benefit, by others a threat.”

“The loss of patients and dollars due to residents choosing not to use care locally available (or that could be developed locally) is a particular threat to maintaining or building a viable rural health system. In urban and suburban markets, competition tends to be among providers located within the same area so movement from one HMO to another doesn’t as easily threaten the aggregate of care locally available.”

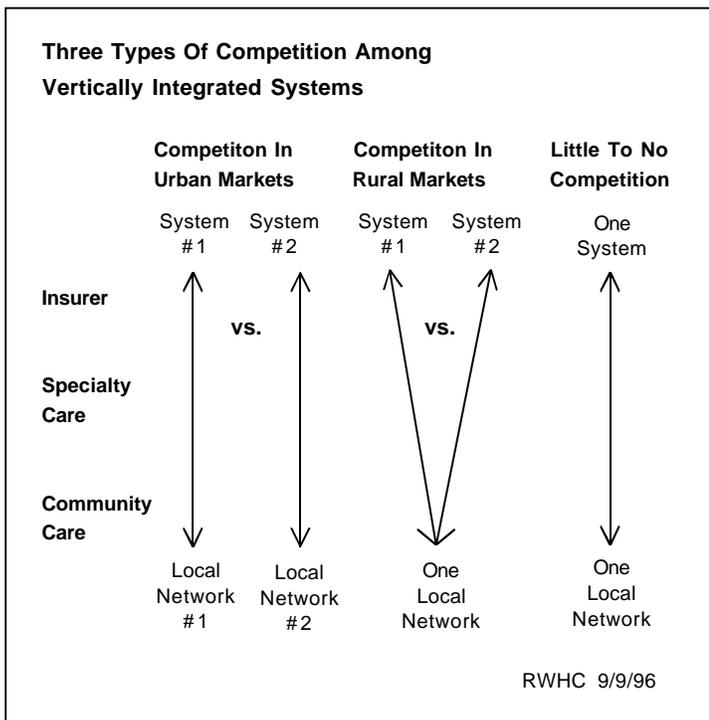
“While traveling an hour or more for care at a regional center is the right of any individual, not all residents have the means or health to do so, not all conditions allow that much time and weather is not always cooperative. Underserved populations are particularly at risk as local care becomes less available.”

“Add to this the very real link between rural health and rural community development and the issue of working to retain and enhance local access to health care is a high priority for most communities. Health care spending represents about 16 percent of this nation’s economic activity. A disproportionately large share of this activity is concentrated in urban areas. Health insurance premiums and tax dollars destined to become Medicare and Medicaid payments flow out of rural communities. The return flow of these dollars is diminished for three interrelated reasons: (1) health services and resources are concentrated in urban areas, (2) reimbursement rates are higher for urban providers

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

Eye On Health Editor: Tim Size, RWHC
 880 Independence Lane, PO Box 490
 Sauk City, WI 53583
 (T) 608-643-2343 (F) 608-643-4936
 Email: office@rwhc.com
 Home page: www.rwhc.com

For a free electronic subscription, send us an email with “subscribe” on the subject line.



along the lines of multiple and competing regional insurers and systems working with a cooperating rural provider base. This contrasts significantly with non-overlapping vertically integrated competing systems or ‘natural rural monopolies’ most frequently referenced in the literature. These alternative models can most easily be visualized as noted in the attached schematic. The implication for rural networking with competitive markets is that attention must be given to both rural-rural collaboration as well as multiple rural-urban linkages.”

Restructure GME to Train Rural Physicians

From the “Innovative Use of GME Dollars Helps Meet Health Care Workforce Needs” in *The Rural Monitor*, Summer 2003:

and (3) rural residents travel to urban areas to seek care.’ (Health Care: A Growth Industry for Rural America, a paper prepared by Sam Cordes and Wayne Meyers for the July, 1997, Capital Area Rural Health Roundtable.)”

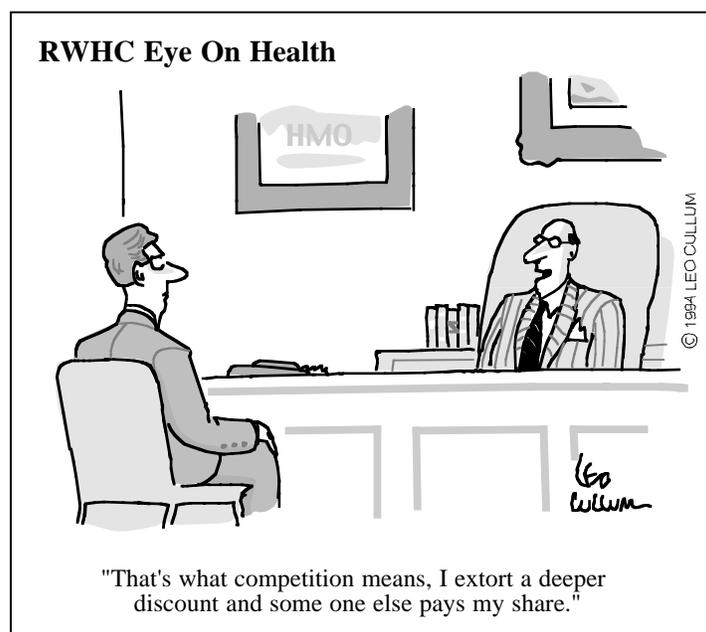
“RWHC’s analysis of its member hospital discharge data clearly showed that Cooperative hospitals compete not with each other but with out-migration. Each member hospital has a clearly defined market with minimal overlap with its immediate neighbors. If people do not choose to receive care locally, they go into a regional center, not another RWHC rural hospital. Antitrust principles do not prohibit the collaboration of providers from separate markets as long as there is a demonstrated opportunity for consumers ‘to flee’ the market and as long as the collaboration does not require exclusivity.”

“While some areas of rural America will probably remain apart from managed care and networking, many areas will evolve

“The Utah Medical Education Council (UMEC) is breaking new ground in health care workforce training through its use of Medicare and Medicaid graduate medical education (GME) dollars, which are the principal source of support for specialty training of physicians.”

“According to Gar Elison, Director of UMEC, a waiver obtained from the Federal Centers for Medicare and Medicaid (CMS) allows UMEC to change the flow of GME dollars in a way that helps the state influence

residency programs and thereby better meet its workforce needs. In the past, GME payments had been made directly to hospitals where residents are trained. Under the waiver, direct GME dollars are carved out and flow to UMEC, which then uses them as a ‘carrot’ by passing them on to residency programs that meet the state’s workforce goals. Elison says that the Council does not commit funds to a program until that program has a plan showing



how it will meet the workforce objectives. The program then has to live up to its plan or have its funding reduced, giving the effort a ‘stick’ as well.”

“Historically, residency programs billed hospitals for the salary and benefits of the residents based on their time in the hospital. Under the waiver, programs bill hospitals a lesser amount because the direct GME dollars now flow to the program directors. Program directors—who hire the residents—are held accountable for achieving the state workforce objectives. Directors are also responsible for meeting accreditation requirements and filling the positions in the program. In short, the waiver rationalizes the process and places responsibility with those who have the authority to link training with workforce needs.”

“Asked if the hospitals object, Elison says that ‘in many ways, they actually favor it—once they understand it.’ Current goals pursued by the program are to increase the rate at which Utah-trained health care graduates stay in the state; expand the size of certain residency programs to meet the needs for various specialties; and develop training experiences that meet the state’s workforce needs, **in particular, to increase the amount of training in rural areas so graduates will know how to practice there.**”

“ ‘Just because it’s rural,’ says Elison, ‘we don’t want any decrease in skills.’ In fact, he says, it’s the other way around. Rural practitioners need to know how to do almost everything.”

“The Council was created by state law in 1997 as a quasi-governmental entity to help collect health care workforce information from various entities without violating anti-trust regulations. The Council, by statute, was also directed to obtain the CMS waiver for a demonstration project for GME distribution.”

“Elison knows of no other state that has linked receipt of both Medicare and Medicaid GME to workforce planning, but says that several are looking into it.”

For more information, contact Elison at (801) 526-4552. [or gtelison@utah.gov](mailto:gtelison@utah.gov).

Hard to Hit Targets You Don’t See

From “AHRQ’s New Prevention Quality Indicators Flag Potentially Avoidable Hospitalizations,” a press release from the Federal Agency for Healthcare Research and Quality, 11/20/01:

“The Federal Agency for Healthcare Research and Quality (AHRQ) has made available Prevention Quality Indicators—a free tool for detecting potentially avoidable hospital admissions for diabetes and other illnesses which can be effectively treated with high-quality, community-based primary care. The AHRQ Prevention Quality Indicators allows users to measure and track hospital admissions for uncontrolled diabetes and 15 other conditions using their own hospital discharge data and provides the information needed to improve the quality of primary care for these illnesses in their community and state.”

“ ‘One way to improve the quality of Americans’ health care is by preventing unnecessary hospitalizations that increase health risks as well as costs,’ said Department of Health and Human Services (HHS) Secretary, Tommy G. Thompson. ‘To do this, we need to be able to track the outcomes of health care services that people receive. AHRQ’s Prevention Quality Indicators will help us do this.’ ”

“For example, research shows that 7.2 hospital admissions per every 10,000 people aged 18 to 64 in the United States are for uncontrolled diabetes. A goal of Healthy People 2010, the Department of Health and Human Services’ (HHS) roadmap for improving Americans’ health, is to reduce hospitalization rates for uncontrolled diabetes for persons in this age bracket to 5.4 per 10,000 people, which health experts agree can be accomplished by improving the quality of outpatient diabetes care and access to such services.”

“The Prevention Quality Indicators represent hospital admission rates for common conditions that also include bacterial pneumonia; pediatric gastroenteritis; urinary infec-

Financing Rural Hospital Capital Improvements

www.raconline.org/pdf/capital_brochure.pdf

Rural hospitals are aging—many face problems that can only be addressed with capital funding:

- Facility not designed for outpatient services
- Major equipment is outdated and beyond repair
- Loss of patients to newer facilities
- Structure doesn’t meet regulatory specifications

tions; congestive heart failure and chronic obstructive pulmonary disease, which if adequately treated by primary care providers, generally do not require hospital inpatient care. The rates are population based and adjusted for age and sex.”

“ ‘Providers, policymakers and others seeking to improve health care need easily accessible and scientifically reliable indicators of quality that they can use to flag potential problems, follow trends over time, and identify disparities across communities and regions,’ said AHRQ Director John M. Eisenberg, M.D.”

“The AHRQ Prevention Quality Indicators can be used to answer a wide array of questions regarding the quality of primary care in a community or region. For example, if a state health department or hospital association wants to know the quality of primary care provided to people in their state for a condition such as diabetes, they would select the AHRQ Prevention Quality Indicators for that illness and use them to measure their state’s hospital discharge data on admissions for diabetes. They would then compare these admission rates for communities within their state with benchmarks such as their state average or national and regional averages available through AHRQ’s HCUPnet.”

“The AHRQ Prevention Quality Indicators are part of the new AHRQ Quality Indicator modules developed by the UCSF-Stanford Evidence-based Practice Center. They represent a refinement and further development of the HCUP Quality Indicators, which were developed in the early 1990s as a starting point for hospitals and health care systems to begin quality assessments using hospital discharge data.”

“Prevention Quality Indicators can be downloaded at: <<http://www.qualityindicators.ahrq.gov/data/hcup/prevqi.htm>>. Users must access the SAS statistical software package to run the programs, which they will then have to apply to their own databases that contain information on hospital discharges.”

Knowing Rights/Responsibility vs Suing Rights

From “Getting the Skinny on Nutrition” by Donna Britt in *The Washington Post*, 3/12/04:

“Those of us who’ve never smoked can only imagine the pull of cigarettes on people for whom smoking is a hated habit. We’d be tempted to feel superior to them—if we’d never eaten.”

The Rural Assistance Center (RAC)

www.raconline.org/about/index.html

RAC was established in 2002 as a rural health and human services "information portal" to help rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents. To accomplish this, RAC gathers and streamlines information from myriad sources and provides easy access to that information.

“Who hasn’t stuffed his or her mouth with food that’s questionable, if not straight-up unhealthy? If I’m half asleep and smell sausage frying, my intermittent vegetarianism retreats before memories of scrumptious, fat-laden childhood breakfasts.”

“No wonder obesity is about to overtake cigarettes as America’s leading cause of preventable deaths, as reported Tuesday by the Federal Centers for Disease Control and Prevention. The combination of Americans’ widespread lack of exercise and less-than-healthy diets has created a fatness epidemic that may soon prove deadlier than smoking. If current trends continue, the death toll from obesity will next year surpass 500,000 annually.”

“One thing is puzzling. Smoking-related deaths have declined for years thanks to cigarettes’ well-publicized link to disease—not to mention government anti-smoking campaigns and the ubiquity of no-smoking areas. Why hasn’t that happened with obesity?”

“In all of human history, there has never been more emphasis placed on the importance of eating right and exercising. Not a day—an hour?—goes by without us hearing about the Atkins, Weight Watchers or gummy bears diet. Hollywood role models such as Nicole Kidman, Naomi Watts and Jada Pinkett Smith couldn’t be tinier.”

“Ironically, the relentless public emphasis on healthy eating and dieting combined with the idealization of

the skinny over the healthy-sized results in beleaguered people saying, 'Forget about it.' ”

“When it comes to weight, ‘the goals seem too lofty,’ says Arlington physician Denise Bruner, who likens the situation to a first-grade teacher dumping on students’ desks ‘all the books they’ll have to read throughout 12 years of schooling. They’d be so overwhelmed, they’d give up.’ ”

“Small changes work. Substituting water for your daily 16-ounce bottle of Coke for two weeks can mean a whole pound lost. Ordering Wendy’s mandarin chicken salad without the dressing cuts 250 calories.”

“So is it reasonable for lawmakers to take away people’s right to sue McDonald’s and others for helping us get fat? The House of Representatives passed the ‘cheeseburger bill,’ which would prohibit people from going to court to blame the food industry for their tubbiness. The measure is about people using ‘common sense in the food court, not blaming other people in the legal court,’ said its sponsor, Rep. Ric Keller (R-Fla.), whose district happens to be home to the owner of the Olive Garden and Red Lobster chains.”

“Why the multibillion-dollar fast-food industry needs special congressional protection escapes me. Few lawsuits have been brought against fast-food giants, and not one successfully. With nearly two-thirds of American adults and 15 percent of kids overweight, fast-food companies should share some responsibility—by clearly labeling their products’ fat and calorie content.”

“Cigarette smokers know exactly what they’re getting, Bruner points out. Few who buy Starbucks’ ‘low-fat’ blueberry scone realize they’re getting a 460-calorie ‘diet’ item. People deserve to know that when they spend 20 more cents for ‘super-size,’ they’re getting an extra 300 calories,’ Bruner says. If they did, she says, ‘they might decide it’s not a bargain in any way.’ ”

Research Matters to You & Your Heart

From “Simpler Method for CPR Coming” by Robert Davis, *USA TODAY*, 2/23/04:

“In what may prove to be the biggest shift in emergency care of cardiac arrest in 40 years, cities across the country are leading a move away from the familiar practice of using mouth-to-mouth resuscitation. In its place, the cities are recommending simple chest compressions—pushing down repeatedly on the victim’s chest—to mimic a steady heartbeat. The emergency medical directors who are behind the shift say research in Seattle and Richmond, Va., suggests it will save many lives.”

“The movement became a full-fledged national trend last week at a meeting of emergency medical services (EMS) medical directors from 21 of the nation’s largest cities. Doctors from a dozen cities, including

New York, Los Angeles and Chicago, decided to make the switch. They join at least seven other cities that already are advising 911 callers to do chest compressions without mouth-to-mouth ‘rescue breathing.’ ”

“Seattle saved more lives by advising compressions alone, and Richmond rescuers arrived to find 10 times more victims (60% vs. 6%) getting lifesaving compressions when not distracted by advice on breathing techniques.”

“For now, the shift applies primarily to untrained bystanders, the group most likely to reach victims in the first critical minutes. In such emergencies, lives generally are saved or lost within six minutes. The emergency directors agreed that trying to talk 911 callers through mouth-to-mouth procedures was doing more harm than good because it wasted time.”

Rural and Remote Health, The International Electronic Journal of Rural Health and Remote Health Research, Education, Practice and Policy

<http://rrh.deakin.edu.au/home/defaultnew.asp>

Their vision is “to serve rural and remote communities throughout the world by providing a community forum and specific health-related information.”

Cooperative Business Model Aids Rural

From "Call for Major New Federal Commitment to Cooperatives to Help Struggling Rural Communities" by The National Cooperative Business Association (NCBA), 2/20/03:

“NCBA is calling for a major new federal commitment to cooperative businesses to boost America’s struggling rural communities. In comments prepared for at the Agriculture Department’s annual Outlook Forum, NCBA policy chief Jeannine Kenney called for both more federal money for co-ops and better coordination across federal agencies so that the ‘promise of cooperatives in sustaining and improving rural communities can be realized.’ ”

“Kenney urged increased funding for several Agriculture Department grant programs that benefit cooperatives, new programs to assist rural communities in starting co-ops, expanding the mission of USDA’s Cooperative Services office to include support for *all* rural cooperatives, and a government-wide coordinating council for cooperative development.”

“Kenney prefaced NCBA’s call for a new commitment to cooperatives with a discussion of all the types of co-ops that could benefit rural America. In addition to farm and electric co-ops, these included forestry co-ops to help manage harvests on private forestland; housing co-ops for both rural seniors and low-income farm workers; healthcare co-ops including consumer-owned HMOs, hospital purchasing co-ops, home healthcare co-ops, and health insurance purchasing co-ops; childcare co-ops, and retail food, hardware and drug co-ops that help independent businesses succeed in rural communities.

“Local control and ownership will keep businesses in rural communities. ‘This is just a snapshot of the non-agricultural co-ops that support rural development,’ Kenney said. ‘There are many more.’ Why co-ops versus other forms of business? ‘Because when there is local ownership and control, there’s a lesser likelihood of the business moving out or closing. And the income and jobs generated by that co-op business generally stay in that community.’ ”

Synergy Between Advocacy & Shared Services

From “The Natural Synergy Between Advocacy & Shared Services” presented by Tim Size at the RWHC 2004 Strategic Planning Retreat:

RWHC Mission: The Rural Wisconsin Health Cooperative (RWHC), begun in 1979, supports and enhances rural health and quality of care. RWHC is a strong, innovative and mutually supportive network of hospitals with diversified services who combine their strengths to meet local community health needs through advocacy and high value products and services. We don’t talk much about the natural synergy between cooperative advocacy and shared services but here are a few examples:

Envisioned in RWHC Mission: As referenced in our Mission Statement, RWHC is to support rural health by combining strength in both advocacy and shared service arenas. Historical note: RWHC was planned first as a shared service enterprise and then discovered while starting up, the complimentary advocacy role.

External Credibility: Advocacy is more credible as RWHC is seen not just as a “mouth piece” or as a “trade association” but as a mission driven group not just talking but adding “real” value.

Similar Infrastructure: Shared services and advocacy require pretty much the same infrastructure of any small to medium sized business. The ability to spread overhead over a broader base has obvious financial advantages. A cooperative of rural hospitals organized for advocacy forms a natural critical mass for shared services and vice versa.

Shared Services Profits Contribute to Operating Margin: Historically, RWHC membership dues have been subsidized both the advocacy function and provided the cash flow to help develop new programs. Compared to other rural networks nationally, RWHC dues are in the low to mid range.

Shared Services Informs Advocacy: Throughout RWHC history, shared services (including roundta-

bles in that definition) have been a major source of advocacy initiatives: examples include:

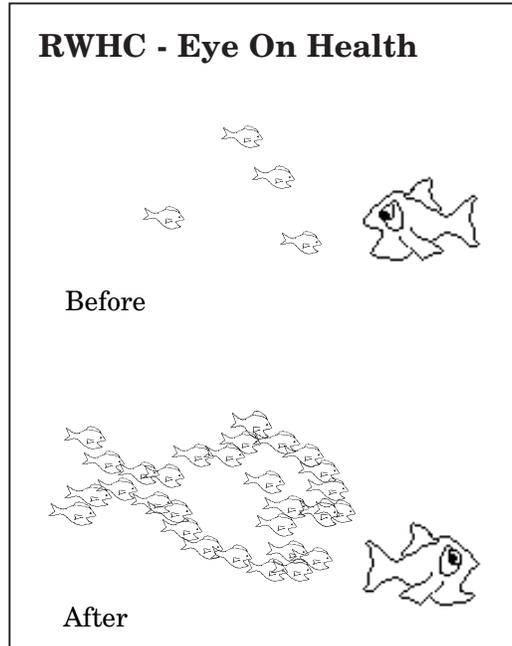
- Quality Roundtables, the ORYX Quality Program and Coding Services have led to an active role in quality reporting policy discussions.
- Network (health plan contracting) led to advocacy re rural access standards.
- Chief Financial Officer Roundtables have led to successful Medicare and Medicaid advocacy.

Advocacy Needs to be Data

Driven: For advocacy to be effective it must be mission and passion driven but also based on the best information available. The Members provide much of that through their governance of RWHC but day to day work requires in-house familiarity and expertise with the broad range of issues faced by the Members: finance, insurance, workforce, quality, etc.

RWHC “Brand Familiarity” Translates from Advocacy to Services to Non-Members: Our statewide and national reputation as an effective voice for rural health makes us a credible source for certain services, particularly those with a strong information component such as our ORYX Quality Measures product and Credentialing Verification Service.

Advocacy Is Not Just Political: RWHC advocacy is also in the market place with health plans, media, vendors, etc. This is done through implementation of the strategic plan for RWHC as a whole and in daily responsiveness to individual requests for assistance on a broad array of issues. Staff’s highest priority is to meet Members needs, both as a whole and as individuals. This is paid by dues but is integral to the resources made available to RWHC through its shared service capacity.



Space Intentionally Left Blank For Mailing