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SEEING GREEN

by Allison Cleary

Bucolic scenes of rolling hills dotted with weathered red barns, white clapboard houses with wide porches and lazy swings, hammocks for two strung lazily between two giant oak trees--this is the Disneyland view of rural life.

But life in rural America isn't a theme park. People--farmers, small-town business people, kids, retirees, moms and dads--get sick. And as more and more rural hospitals merge and reorganize the way they deliver health care, it's clear to those who run them that to keep competing they will have to keep adapting. After all, pastoral scenery is no antidote for rising health care costs, falling Medicare reimbursements, and the expansion of managed care.

If rural hospitals are to survive--and with the proper planning and guidance, experts say they can--they must reach beyond the boundaries of their own geography. From the netherlands of northwest Washington state to the swamplands of Florida, those who run rural hospitals are groping for answers. Smack in the center of the country, however, in central and southeastern Wisconsin, a group of 22 hospitals have found not only safety in numbers, but also a way to preserve their independence.

These community hospitals are all members of the Rural Wisconsin Health Cooperative, a 16-year old network that describes itself not only as a "shared services organization", but almost as importantly, a voice for rural health issues. In fact, the members say the co-op is integral to the survival of many of Wisconsin's community hospitals. At a time when rural hospitals around the nation are desperately trying to keep from sinking, most members of the co-op enjoy financial stability, says executive director, Tim Size.

Survival techniques vary depending on the hospitals' locations and individual situations. Some sit geographically close to urban centers, while others remain isolated from the current acquisitive scope of HMOs. What follows are profiles of three cooperative members. Each differ in their strategies, but all give credit to the cooperative, in part, for fostering their ability to survive.

SERVICE, SERVICE, SERVICE

Prairie du Chien Memorial Hospital has served this community of 6,000 on the Mississippi River for almost 40 years. It has seen hard times but is currently debt-free, has \$4 million in cash, and last year operated under a 15 percent margin. Ask CEO Harold Brown for a detailed blueprint of the hospital's game plan and he will offer one only word: Diversify.

"We do everything," he says, "from emergency room to acute to skilled nursing and intermediate care, to respite care, home health, durable medical equipment, home oxygen, and hospice."

And the list goes on: a community child care center, independent living for seniors, a family resource center, meals-on-wheels, a nutrition site for the elderly, even a cloth diaper service. All this with a staff of 240 and salaries that are 15 percent above those surrounding communities.

"People around the country say we can't be everything to everybody, yet that broad range of services is the reason we're financially ahead," says Brown, who as president of the National Rural Health Association speaks to small-town colleagues nationwide.

Not all services generate income for the hospital. But even those that don't--such as meals at the elderly nutrition site--reap profits. "People come into our cafeteria five days a week and we get to know them one on one. When they need other services, they'll use our facility rather than truck to LaCrosse, which is 65 miles away. On an average day we give over 300 people some kind of health care service."

"If every day you're out there and are [treating] 300 people in your community, that's the same as being in an urban

hospital where you've got 300 acute patients.”

More than 60 percent of Prairie du Chien Memorial's acute patients are Medicare beneficiaries, a number typical of rural health care facilities and one that has crippled many with low reimbursements. But diversification has helped Prairie du Chien avoid financial pitfalls.

Twenty years ago Brown worried about the low number of acute patients at Prairie du Chien. Today, they supply less than half of the hospital's net income. Because of low Medicare reimbursements, he says, “We've gotten to the point that the less acute patients we have the better off we are.”

And diversification will preserve Prairie du Chien's future as well. Brown predicts that HMOs will eventually begin contracting for continuums of care; when that happens, hospitals like Prairie du Chien--the ones that have developed all these resources under one management--will have positioned themselves beautifully.

So where does the Rural Wisconsin Health Cooperative factor into Prairie du Chien's success? Monthly departmental roundtables between employees at different facilities provide a forum to evaluate problems. In this way, no one feels as if they're the only one facing a particular issue. Learning from the experiences of colleagues helped Brown's staff avoid some of the pitfalls associated with the start-up of new services.

More important, perhaps, is the Cooperative's political muscle: It has been instrumental in changing the inequities in Medicare reimbursements for urban and rural health care services. What was once a 40 percent difference is now about 15 percent, according to Size, and he hopes to close that margin even further.

STAFFING UP

At Columbus Community Hospital, only 20 minutes from Madison, closing the pay gap between rural and urban doctors factored into the hospital's formula for a financial turnaround. Ten years ago, Columbus reversed a six-year history of losing money, says administrator Miles Meyer. This year, he adds, the hospital has made more money than ever before.

When Meyer came on board in 1985, he aggressively recruited specialty and primary care doctors who could help build community confidence in the hospital, located in a town of 4,500. The addition of three family practice doctors, an obstetrician, and several surgeons within the last three years has helped Columbus buck a national trend: Inpatient admissions have increased at the hospital by about 10 percent in the last two years.

“The driver behind managed care is to have the appropriate level of care provided at the appropriate setting, and that setting is being defined by cost, quality, and access,” he says. “Our cost structure wasn't out of line,” Meyer continues. “Being this close to the Madison market, we needed to make sure we were competitive so we could retain and recruit adequate and qualified staff.”

But quality could be improved in certain areas. For example, the hospital updated equipment in the surgery department and used the improvement to convince specialists that Columbus was on a par in terms of its available technology with the big urban facilities. A management services agreement with Meriter Hospital, a surgical facility in Madison, also helped.

Through the connection between the two facilities, surgeons unfamiliar with Columbus Community Hospital had the chance to work there. They saw firsthand that “scheduling was better [at Columbus], they had continuity of the staff in the operating room, and they had confidence that the patients would be cared for very well after and during surgery,” Meyer says.

Columbus Community Hospital also improved quality through the establishment of joint services such as audiology and physical therapy, services that the hospital couldn't cost-effectively provide on its own. The Rural Wisconsin Health Cooperative also offers its own physician credentialing and staffing for emergency rooms, and educational programs.

The hospital can't afford an expensive information system, but Meyer says that working with the co-op has provided a large enough experience base to do comparisons and demonstrate the quality of the health care in these rural hospitals for potential alliances with PPOs and HMOs.

For rural organizations like Columbus, moving forward in realms like quality documentation means making progress in areas of vital and immediate concern to their present--and future--payers.

DOING THE RIGHT THING

Recruitment was also integral to a financial turnaround at the very rural Mile Bluff Medical Center in Mauston, a town of 3,500 people an hour and a half's drive from Madison.

"At one point, in 1976, we were down to three physicians," says CEO Dan Manders. Today, the hospital boasts 10 family doctors, a surgeon, a podiatrist, physician assistants and nurse practitioners. As a result, acute admissions at the 40-bed hospital have risen to an annual 2,400. The upswing has not been "one of those miracle turnarounds you read about," he says. "It's just been a long arduous process of keeping on the right track." Manders' motto: "If you can't do it with high quality, don't do it at all." So, for example, the doctor-hungry organization found itself passing up some early applicants to the medical staff because they weren't board-certified. And the hospital won't build an in-house magnetic resonance imaging unit because executives don't feel that the 360 MRIs a year performed in its mobile unit justify the creation of a full in-house service.

Mile Bluff is now constructing an addition to its original building and remodeling part of its old facility to accommodate the explosion taking place in outpatient services and acute admissions. "Our reputation has made people in the community comfortable that we'll do here what we can do right --and if it needs to be done elsewhere, we won't think twice about transferring them," Manders says.

The Rural Wisconsin Health Cooperative has factored into Mile Bluff's success through the networking it promotes. "When I first became president here, I was pretty young and green and needed advice," says Manders, who has been with the hospital for 21 years, 14 of them as CEO. "The co-op offered me a whole spectrum of people I could go to for advice. Now that I've got the experience, I try to provide that for the people who are new to the positions."

Adds co-op chief Size, "The hospitals are still very clearly autonomous, but the co-op is an alternative to both what I call this John Wayne independence, which is largely dead now, and the other extreme, which is total consolidation."

"We try to step back and look at the whole picture, to see the connection between various elements: recruitment, reimbursement, education," he says. "If we could get medical students and residents to have part of their training in rural areas, we know they're more likely to choose to practice there." But because the reimbursement is lower and the student may have large loans, we've also worked with other parties in Wisconsin to implement a loan-forgiveness program."

"All the pieces connect. That's the wonderful thing about a network," Size concludes. "You can work across the board".

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