

CRISIS IN THE COUNTRYSIDE

Hospitals and clinics in rural America face many of the same challenges as urban facilities: access to the capital needed to meet the technology demands of physicians and patients; competing strategies in quality/safety advancement and clinical program growth; aging plants; workforce and provider shortages; leadership development in a rapidly changing management environment; and such business issues as revenue-cycle management, heightened consumer expectations, and influencing local and state legislative policy and funding. However, the resources available to rural care—or, rather, the lack thereof—demand especially creative answers to these challenges.

Rural health care is a significant component of the health care delivery network in America. More than 54 million people, roughly 18 percent of the U.S. population, live in areas served by about 2,200 rural hospitals.¹ Moreover, the populations in rural areas are on average older and, therefore, use health care services at a higher rate than do their urban counterparts. In addition, non-senior citizen rural patients have a greater likelihood of being underinsured or uninsured.

Catholic organizations represent a proportionally greater percentage of rural health care than do other-than-Catholic ones: Catholic facilities constitute 11 percent of all U.S. hospitals and 26

Networking and Telemedicine Are Crucial for Health Care Facilities in Rural America

BY M. MICHELE HOOD

percent of rural health providers.² Because a significant number of Catholic health care facilities are in rural areas, and because their share of the total care there is proportionally larger than that of other-than-Catholic care, the ministry has great opportunities for advocacy. Maintaining the tenets of Catholic identity while providing health care in clinically isolated communities offers additional challenges, especially concerning several of the requirements included in the *Ethical and Religious Directives for Catholic Health Care Services*. In communities where a Catholic facility is the sole provider, issues involving, for example, care at the beginning of life, can create community-relations problems and reduce opportunities for networking. As in other cases, creative solutions may be needed.

It is informative to observe those rural hospitals that have achieved "critical access" designation. The designation was created in 1997 to ensure Medicare beneficiaries' access to health care services in rural areas, by giving participating hospitals enhanced Medicare and Medicaid reimbursements. As of November 2003, there were 835 critical access hospitals (CAHs) in the United States—up from 36 in 1998.³ (See Robert A. Dockter, "Health Care on the Plains," p. 31) And, despite the perception that rural facilities are important only in the breadbasket or great frontier states of our country, every state but five (Rhode Island, Connecticut, New Jersey, Delaware, and Maryland) has at least one CAH. Indeed, the number of CAH-designated hospitals is growing, with another 48 rural facilities joining the ranks since July 2003. In states with rural hospitals, the proportion of rural hospital beds to total hospital beds ranged in 2000 from 1 percent (Massachusetts) to 80 percent (Montana). Let's take a look at some of these challenges and some tactics which are being engaged to create a stronger rural health service.



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Finally, it is important to note the recent Medicare modernization legislation and its positive impact on the provision of additional resources for rural health care. Improved reimbursement will assist rural facilities in meeting all of the challenges. I wonder, however, whether this is not just another Band-Aid in the increasingly desperate efforts to hold our existing health care financing and delivery system together.

ACCESS TO CAPITAL/TECHNOLOGY

With the recently enacted Medicare modernization legislation, rural providers have been provided a modicum of financial relief. Together with the growing utilization of the CAH designation and the associated benefit of more reasonable Medicare and Medicaid payments, rural providers' balance sheets have been strengthened. However, many of the nation's rural hospitals have built up a long list of needs. In order to most effectively utilize the limited resources available, rural facilities are increasingly relying on networks of technology rather than on independent access.

Through collaborative approaches to partner hospitals and other rural and tertiary facilities, small hospitals can gain access to both business and clinical technologies otherwise limited to larger facilities. The cost of these technologies (e.g., information systems, imaging, and others) is often difficult to justify, because of the relatively small populations served by them, and some rural facilities that invested in them have been unable to meet return-on-investment triggers.

Now, however, with the recent advances in telemedicine applications and associated reforms in reimbursement methodologies and provider credentialing requirements, the promise of networked services is brighter. For example, the Sisters of Charity of Leavenworth Health System's network of CAH-to-tertiary-level facilities is in the early stages of applying telepharmacy technology. This will allow our smallest facility to have the advantage of 24-hour-a-day pharmacy services, managed from the tertiary site. This application will improve patient services and quality outcomes through timely dispensing of medicines, especially in those very small rural communities whose straitened economies have forced retail pharmacies to leave the market.

The use of technology to remotely monitor critical and high-risk patients, or to assist in the diagnosis and treatment of emergency patients, is also increasingly common. Our system is currently working, along with partners in academia and device manufacturing and design, to make remote monitoring and treatment devices available for high-risk diabetic and cardiac disease patients. Because CAH and other rural hospitals are typical-

ly at a distance from additional clinical resources, such devices, which will enable them to take advantage of advanced subspecialty expertise and deliver it on a real-time basis, can only increase the quality and value of their health care services.

These types of applications are beginning to produce a positive return on investment from the capital investments made in the networks of telemedicine technology installed in the past decade.

Access to public and private grants and federal appropriations is an invaluable resource for rural health care providers in their development of these innovative approaches to clinical care. These revenue sources allow start-up funding and technology acquisition. Provider networks are in general attractive to grantors and to Congress, and rural networks are particularly attractive because their typically homogenous patient populations and limited number of providers tend to make monitoring them a simple process.

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COMPETING STRATEGIES

In any hospital today, the possibilities for resource allocation tremendously outstrip the resources (of management time, expertise, and finance) involved. Typically, one of the greatest management challenges is focusing the organization's strategy and efforts so that results are symbiotic and move the organization toward improved health for the community it serves. Choosing from among the myriad of new programs and clinical improvement efforts in a way that complements the organization's strengths and meets market demand—versus, on the other hand, being fragmented and shallow in clinical programmatic offerings—is a high risk for every organization. Determining how and with whom to partner to build a consolidated and progressive, vertically and horizontally integrated network of services is an added strategic task.

In rural areas, these challenges are exacerbated by the fact that the hospital normally cannot specialize. Because it is in most cases the community's only source of health care, the facility must be prepared to respond to a wide range of needs. This is especially true of Catholic facilities, committed as they are to serving the uninsured and the underinsured. To solve this dilemma, Catholic hospitals in rural areas must aggressively pursue the formation of networks of providers of service line-specific programs and services, including preventative and rehabilitative care. Such networks will result in both increased consumer satisfaction and increased value (higher quality at less cost).

Next, consider the growing emphasis on quality and patient safety, including more sophisti-

cated metrics for public disclosure. Every hospital leader in America knows firsthand that today pressure for more and better publicly available information concerning the quality of hospital care comes from every direction. State and federal government has been moving steadily ahead in this area for years. Today there are multiple public sources of quality measures, including the Joint Commission on Accreditation of Healthcare Organizations, the National Quality Forum, insurers and other payers, the business community, consumer organizations, commercial enterprises that compile and sell "report cards," and the media.

Rural hospitals are meeting these challenges. During the 1990s, rural hospitals either provided more services themselves or joined forces with other providers to expand the number of services available in their communities. Rural hospitals converted their excess beds to provide new inpatient services; growing numbers of rural hospitals offered psychiatric inpatient services, rehabilitation services, swing bed services, skilled nursing care, and hospice services. And in many states, Montana among them, CAHs have networked to develop a meaningful quality-improvement and patient-safety agenda.

AGING PLANTS

The age of their physical plants is often a significant problem for rural hospitals. Many were either originally county-owned and -operated facilities or Hill-Burton facilities, constructed with federal funds in the mid-20th century.* In a recent study, one state reported that the average age of its rural facilities was nearly twice that of its nonrural ones, indicating a deferral of capital improvements in the former and a concomitant need for them to receive capital infusion if they are to maintain safe environments and acquire needed technologies.⁴

A significant percentage of rural hospitals have attached long-term care facilities. The growing use of swing beds—which can serve both acute and long-term needs, as patient demand changes—allows such facilities to improve their space efficiencies. Having done that, they must, by improving operating performance, build the appropriate debt capacity so that plant and technology needs can be gradually addressed. As I said earlier, access to alternative revenue sources through grants and federal appropriations should be considered an important component in the financial planning equation.

*The Hill-Burton Act of 1946 provided federal grants for the modernization of U.S. hospitals.

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WORKFORCE AND PROVIDER SHORTAGES

Hiring physicians, registered nurses, radiology staff, and laboratory personnel is especially difficult for rural hospitals. The strategies found most successful in recruiting nurses and other clinical staff are word-of-mouth networking and "grow-your-own" educational scholarship programs. Recruiting in rural America calls for specialized tactics. Local community colleges will likely become important partners for hospitals in the creation and maintenance of needed training programs. Through creative planning, educators and providers can together develop distance-learning and flexible technical/degree programs with which they can train nontraditional students to help meet these workforce challenges. (See Max A. Morse, "'Teleschooling' May Be the Answer," p. 25.) And to encourage more young people to enter health care fields, and to slow the flight of youth from rural communities, hospitals must begin partnering with high schools even elementary schools in this regard.

Physician staffing challenges are growing worse in rural health care. One in every six surgical positions is unfilled, for example, and acute shortages exist in key surgical specialties.⁵ According to a recent study, the surgical specialties most in demand in rural health care (and the percentages of hospitals and clinics searching for them) are:

- Orthopedic surgery (41 percent)
- Urology (26 percent)
- Gynecology (22 percent)
- Otolaryngology (13 percent)
- Neurosurgery (11 percent)⁶

It is increasingly common for rural communities to have multiple specialists, as diversification of services continues. However, those communities may have only one provider in a single specialty. And many CAHs may have no more than one or two physicians supported by physician assistants or other midlevel providers. When vacancies occur, or a need for more specialized services arises, patients must travel outside the community to find the care they require. Fortunately, provider networks and telemedicine are helping hospital administrators fill vacancies and find substitutes for vacationing physicians, as well as supplementing the complement of local providers with specialists and subspecialists on a part-time basis.

LEADERSHIP DEVELOPMENT

Today more than ever, health care needs creative, imaginative, and risk-taking leaders who can, at both governance and management levels, choose the options that will take their organizations successfully into the future.

Governance's ultimate responsibilities are:

- Envisioning and formulating the organiza-

tion's mission, vision, and goals

- Ensuring high levels of executive management performance, with a focus on the only employee who reports directly to the board, the CEO

- Ensuring the quality of patient care
- Ensuring the organization's financial health

Recruiting talented trustees is both easier and more difficult in our rural facilities. Because the hospital is often the community's leading employer, local interest in the organization's strength and strategy is usually extremely high. Because this is so, business and community leaders are more easily engaged. Then, too, there is little strong competition for the talent of these leaders from other organizations.

On the other hand, hospitals find it more difficult in small, rural communities to find all the skill sets traditionally sought in building boards. The complexities of today's health care make it very important that hospital boards have a wide diversity of experience and expertise, including marketing, entrepreneurship, finance, real estate, legal, retail, and social services.

Developing talented management teams is, for rural hospitals, as great a challenge as recruiting skilled workforces. Because of the size and scope of services of such facilities, their front-line managers must often be working managers, which requires them to have a mix of clinical/technical and management skills. Unfortunately, it is increasingly difficult, in today's sophisticated health care, to find people able to fill this dual role.

CONSUMER EXPECTATIONS

According to the Institute for the Future, today's empowered health care consumer wants:

- To be involved in decisions related to his or her health care, including plans, providers, and treatments (choice)
- To be more active, more engaged in his or her health care (control)
- To receive the same superior customer service he or she has come to expect from retail businesses and financial institutions (customer service)
- To find reliability and consistency in health care services (branding)
- Access to current, relevant, and accurate information that will assist him or her in decision making (information)⁷

Although rural hospitals usually have little competition for their services, they find that people in their communities want the same things urban consumers want. For example, rural hospitals are discovering that, like city people, rural people increasingly want outpatient rather than inpatient services; they prefer the convenience, service, and consumer control of outpatient care. In urban areas, these services are often best pro-

vided by physician-hospital partnerships. Unfortunately, rural communities offer limited opportunities for such programs. Because that's so, the responsibility for developing new outpatient services is frequently left to capital-strapped rural hospitals. Exacerbating this service-shift exigency is the demand it places on physical plants that are not amenable to outpatient flow.

Consumer demand has led hospitals to add additional services in increasingly convenient and sophisticated settings. Rural hospitals, trying to keep their patients from going to city facilities, have been part of this trend. Between 1994 and 2000, for example, rural hospitals were increasingly likely to offer sophisticated diagnostic imaging services, either on their own campuses or through affiliates. The jump in the number of hospitals offering MRI imaging services was particularly strong. More complex, invasive procedures, such as radiation therapy and cardiac procedures, also increased in those years. Growth in the number of hospitals offering assisted living and retirement housing continued throughout the period as well.

As they seek creative solutions for these development needs, health care facilities today are moving increasingly toward more diversified services, offered through linkages with other institutions and provider groups. Models that combine rural facilities with academic teaching or modifications of a "hub-and-spokes" arrangement offer some promise of improved efficiencies and increased horizontal and vertical integration in our rural communities.

INFLUENCING POLICY AND FUNDING

Today leaders of rural health care organizations, trustees as well as administrators, are in a position to play key roles in their communities vis-à-vis both health care-related issues and issues in general. They must play those roles for two reasons. First, a rural facility is usually a leading employer in its community and an essential part of its social and economic identity. Second, a rural hospital is, because of its small size and inability to absorb additional administrative burdens and shift costs, normally very sensitive to public policies, especially those involving regulatory and payment matters.

Therefore, the typical rural health care leader, although already stretched in time and energy by all the challenges outlined above, must see to it that public policy issues are on his or her monthly (if not weekly) agenda. Such leaders have a unique opportunity to influence policy, not just locally but at the state and national levels as well. Indeed, it is *because* rural leaders face those special challenges that they have this unique opportunity.

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STARTING A FREE CLINIC IN A RURAL AREA

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Sojourner magazine has written: "We don't have any blueprints for a new system. . . . At best, what we have are some spiritual guideposts and road maps. The process of change will feel more like a journey than a policy conference or board meeting. *And the sojourn itself is a part of the solution* [emphasis mine]."⁸

So those of us who seek health care reform are on a "sojourn" of faith and hope, love, and promise. Where will the sojourn lead us? How will we respond to the ever-growing need for health care? How can we overcome the obstacles that make modern-day health care such a bureaucratic quagmire? Seen this way, genuine reform looks almost Sisyphian.

The answer to this conundrum is to be found in faith. As one writer has said, "True faith—the only actually salvific faith—is faith informed by love, faith that becomes the practice of solidarity and liberation: orthopraxy."⁹ Faith, in regard to service, is characterized by love in action. We who work in the NewHope Clinic are determined to help provide loving caring service to the marginalized of our society. We are on a mission to bring God's tender care and loving mercy to the working poor of Owingsville and the surrounding area. We are determined to be people for whom faith is more than a word, people who believe that faith is primarily a praxis.

How do we as health care providers look at our role in an ethical manner? I have come to believe that, ethically, we as providers of care are obligated to become the persons we were meant to be. But how do we become what we already are? How do we determine not only what God wants of us, but also what we are in actual fact in God's eyes? Thomas Merton wrote: "God utters me like a word containing a partial thought of Himself. A word will never be able to comprehend the voice that utters it. But if I am true to the concept that God utters in me. . . . I shall be full of His actuality and find Him everywhere in myself."¹⁰ Merton,

it seems to me, is saying that in order to be myself I must abandon any idea of who I am and seek my identity in God alone. Only in absence of self and presence of the Self, can I truly act, and only then will my actions be completely honest and true. When I serve others, I do so at the very center of my self, and God does the work, not in me or in spite of me, but through me.

So I've come to believe that in order to be the best possible health care provider, person, activist, missionary, Christian, and parent, I must become fully what God wants me to be; I must allow myself to be discovered by God. "Our discovery of God is, in a way, God's discovery of us," Merton wrote. "We cannot go to heaven to find Him because we have no way of knowing where heaven is or what it is. He looks at us . . . and His seeing us gives us a new being and a new mind, in which we also discover Him. We only know Him insofar as we are known by Him."¹¹ □

NOTES

1. John P. Kretzman and John L. McKnight, *Building Communities from the Inside Out: A Path toward Finding and Mobilizing a Community's Assets*, Northwestern University Press, Evanston, IL, 1993, p. 5.
2. Kretzman and McKnight, p. 6.
3. Jim Warren, "Free Clinic Opens in Owingsville," *Lexington Herald Leader*, October 29, 2000, p. B1.
4. Berry, Wendell, *What Are People For?* North Point Press, New York City, 1990, p. 9.
5. Thomas A. Droege, "Congregations as Communities of Health and Healing," *Interpretation*, April 1995, p. 119.
6. Droege, p. 128.
7. "Reality Check," *The Lexington Herald Leader*, October 21, 2000, section A.
8. Jim Wallis, *The Soul of Politics*, New Press, New York City, 1994, p. 147.
9. Leonardo Boff, *Cry of the Earth, Cry of the Poor*, Orbis Books, Maryknoll, NY, 1997, p. 5.
10. Thomas Merton, *New Seeds of Contemplation*, New Press, New York City, 1995, p. 37.
11. Merton, p. 39.

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RURAL CARE IS A KEY COMPONENT

Providing improved access to health care for rural Americans is a key component in improving the overall quality and reducing the cost of health care services in the United States.

We Americans have entered an era of health care networks, alliances, and service systems. A desire to reduce fragmentation, cut duplication, and maximize consumer value—these factors are making the isolated facility a thing of the past. Although true of all health care services, this is particularly true of rural facilities, where the threat of local competition is minimal and the ability to partner and network provides tremendous opportunities. As a result, rural hospitals increasingly have one or more organizational links. Networks, alliances, and service systems enable rural hospitals to meet more of the demands of today's health care environment.

Rural health care is the backbone of services for many Americans—and for many of the neediest: the elderly and the uninsured. The role of these hospitals in the U.S. health care "safety net" is critical. Meeting the challenges of service in today's rural environment is particularly difficult. Even so, many organizations are maximizing the opportunities. □

NOTES

1. See www.hospitalconnect.com/shsmc/resources/profilesofhealthcarerural.html.
2. Catholic Health Association, *Ministry Engaged*, September 2003, p. 2.
3. AHA News, November 17, 2003.
4. Office of the Auditor, State of Hawaii, *Follow-Up Study of the Hawaii Health Systems Corporation*, April 2002, p. 48, available at www.state.hi.us/auditor/reports/2002/02-09.pdf.
5. "Rural Docs Still in Short Supply," *Business Journal of the Greater Triad Area*, Greensboro, NC, March 26, 2003.
6. "Rural Docs Still in Short Supply."
7. Institute for the Future, *Health and Health Care 2010: The Forecast, the Challenge*, 2nd. ed., Jossey-Bass, San Francisco, 2003, Chapter 10.