Rural System Addresses Social, Economic Needs

Cooperation, Education, and Advocacy Revitalize a Region's Healthcare Delivery

Convinced that a vital rural healthcare system requires regional cooperation and strong small-town economies, leaders at Presentation Health System (PHS), Sioux Falls, SD, have redefined and enlarged the system's mission.

In recent years PHS, which is sponsored by the Sisters of the Presentation of the Blessed Virgin Mary, has expanded its services to provide support for rural leaders in business, politics, and education as they shape their communities' economic futures. At the same time, the system has developed a number of programs that emphasize regional networking and cooperation.

According to Sr. Mary Denis Collins, PBVM, PHS's vice president of administrative services, dwindling resources and changing utilization patterns dictate that rural providers stress cooperation and efficiency. "Today more than ever small rural hospitals must rely on organizational affiliation with large tertiary centers," she explains. Smaller hospitals must also collaborate with one another and tap local and regional resources. "Networking," Sr. Collins emphasizes, "is the key to survival."

Community Outreach

Through its two-year-old Center for Rural Health and Economic Development, PHS educates rural community and healthcare leaders in economic development, teamwork, and negotiating strategies.

Education Educational outreach coordinators have created programs broad and flexible enough to address the needs of the entire rural community. The center's staff can tailor courses to the general public, healthcare providers, or other groups; accommodate small or large groups; and offer consultation, pamphlets, or speakers' bureaus. Program topics include healthy life-style, farm safety, the future of rural healthcare, Medicare and Medicaid regulations, the role and responsi-

Summary In recent years leaders at Presentation Health System (PHS), Sioux Falls, SD, have expanded their mission to help strengthen local communities economically and socially.

PHS now offers support to rural leaders in business, politics, and healthcare through its Center for Rural Health and Economic Development. In addition, educational outreach coordinators have created programs that address the needs of the entire rural community.

To establish an effective network of services in the region, two of the system's tertiary care hospitals are collaborating to provide emergency helicopter service. These larger facilities also extend outreach services to rural hospitals and clinics. PHS assists rural hospitals in grant writing and in adapting to changing government reimbursement rules. In addition, the healthcare system coordinates a group purchasing program and a debt collection agency.

An important voice for its region's healthcare needs, PHS has worked with the state of South Dakota to address problems and concerns about emergency medical services. The system also publishes *Report*, a quarterly newsletter that keeps rural residents abreast of healthcare issues affecting them.

Two years ago, PHS's Center for Rural Health and Economic Development sponsored its first Invitational Rural Health Leadership Conference. These annual conferences bring together leaders to examine ways to improve rural healthcare delivery by strengthening the social and economic fabric of rural communities.

Emergency services are critical to rural communities. McKennan Hospital, Sioux Falls, and St. Luke's Regional Medical Center, Aberdeen, will make emergency helicopters available to eastern South Dakota communities.

bility of board members, and quality assessment in healthcare.

According to Sr. Collins, the PHS mission directs the system to make its resources and expertise available to any organization or person in its service area who needs them. "Most often the hospital is a rural community's largest industry and biggest employer," she explains. "As such, it is a key factor in the community's economic survival."

Healthcare Network In the midst of increasing costs and diminished utilization, PHS has searched for efficient ways of concentrating and distributing services.

Establishing effective emergency care is particularly challenging for rural healthcare providers. PHS is currently organizing a joint venture between its two eastern South Dakota tertiary care facilities to create an air ambulance service. Under the arrangement, McKennan Hospital in Sioux Falls (in the southeastern part of the state) is collaborating with St. Luke's Regional Medical Center in Aberdeen (in the northeastern part of the state) to make emergency helicopters available to communities throughout eastern South Dakota.

These medical centers also provide a number of services to hospitals, nursing homes, clinics, and other organizations in eastern South Dakota. According to Dale Stein, St. Luke's president and CEO, the Aberdeen facility has more than 200 agreements offering nearly 20 different outreach services, many of which are delivered by a daily courier, to communities in northeastern South Dakota (see **Box**).

Management Expertise

In helping rural hospitals survive almost a decade of crisis, PHS leaders have continually refined their role. When the rural economy weakened dramatically in the early 1980s, PHS leased a number of economically threatened South Dakota hospitals. The practice allowed system leaders to take a more hands-on approach to improving these facilities' fiscal performance, but it also entailed greater economic risk for PHS.

The system now restricts its role to providing administrative and managerial expertise to rural facilities, while avoiding the potential economic burden involved in leasing. One such "managed" PHS member is Hand County Memorial Hospital, Miller, SD, whose administrator is a system employee. PHS has similar relationships with four other county and community hospitals.

Needs Assessment As PHS President John Porter explains, one of the system's primary goals is to give rural providers access to expertise they could not afford on their own. "With all the demographic and utilization changes rural hospitals have to contend with," he says, "it is important to have the assistance of someone who understands the impact of these changes and can help

ST. LUKE'S OUTREACH SERVICES

St. Luke's Midland Regional Medical Center, Aberdeen, SD, offers a variety of services to community organizations such as hospitals, clinics, nursing homes, physician offices, schools, and businesses. The services include:

- Occupational and speech therapy
- Medical records (consulting and x-ray transcription)
- Patient and family services (consulting)
- Pathology (consulting)
- Biomedical engineering
- Laboratory services
- Medical technology
- Fetal monitor data transmission
- Dietary outreach (consulting)
- Speech therapy
- X-ray supplies
- Mobile mammography, ultrasound, and CT
- Sports medicine (consultations, referrals)
- Holter monitor
- Electrocardiograms
- Accounting
- Therapeutic massage

adapt a community's healthcare services to new needs and conditions."

PHS's Center for Rural Health and Economic Development offers community assessments and health and management audits. The Community Assessment Program begins by evaluating a community's strengths and weaknesses in honest, quantifiable terms. The center encourages community-wide involvement in plans to improve healthcare services and enhance economic development. Health and management audits, conducted by center staff, assess the viability of a healthcare facility's operations and structure.

Grant Writing One of the early initiatives at PHS's Center for Rural Health and Economic Development was to assemble a grant-writing team to help local communities fund planning for changes in their healthcare delivery systems. The center's grant writers have established relationships with many of the foundations and governmental agencies that make such funds available. In the past two years, Porter reports, the team has brought in almost $2 million in grant money.

A significant funding source for rural providers is the federal government's Rural Health Transition Grants, which help communities create new, more effective delivery models for rural healthcare. "Recipients can use funds to analyze such factors as demographics and utilization patterns or what type of physician or physician-extender component a community can support financially," Porter points out.

He adds that some providers use the funds to analyze how they can work with other communities through joint ventures or shared resources. "The grants encourage networking," Porter says. "Although some of the money goes to small capital improvements like renovating clinics, the majority is used to develop models for working with other area providers and communities" (see **Box**).

Reimbursement Review In addition to helping rural providers adjust to changing healthcare utilization patterns, PHS assists members in adapting to constantly changing government reimbursement rules.

"With the advent of diagnosis-related groups and the resource-based relative value scale, system personnel with extensive medical coding and medical records background can be of great benefit to our members," Porter says. PHS staff visit rural member facilities at least twice a month and review every Medicare and Medicaid discharge for accuracy. "We've been able to increase members'

RURAL HEALTH TRANSITION GRANTS

In 1990 staff at the Center for Rural Health and Economic Development put together a joint grant application for hospitals in the South Dakota communities of Miller, Redfield, and Britton. Each of the providers was awarded an annual Rural Health Transition Grant of $50,000 for three years. The hospitals are using part of the money to recruit and retain physicians. They are also using grant funds to study the feasibility of sharing technical personnel and mobilized technology (e.g., ultrasound, x-ray equipment).

The Rural Health Transition Grants can help fund plans for wholesale changes in local healthcare delivery as well. A grant awarded to Holy Rosary Hospital in Miles City, MT, has allowed the hospital to plan a smaller, more efficient facility and at the same time consolidate other community healthcare services, according to Anthony Pfitzer, Holy Rosary's president and chief executive officer. Planners are hoping to relocate from the 6-story, 40-year-old, 100-bed facility Holy Rosary currently occupies to a single-level, 36-bed hospital on a campus adjacent to the interstate. The facility would also include a medical office building capable of housing 20 health practitioners.

Holy Rosary planners are using some of the grant money to pursue a proposal for taking over operations of a county-run 121-bed nursing home, which needs significant repairs. Under the proposal, Holy Rosary would construct a new 121-bed nursing home on the same campus as its hospital and clinic. Ownership and operation of the long-term care facility would be transferred to Holy Rosary.

PHS grant writers also helped Holy Infant Hospital—a community hospital in Hoven, SD—and St. Luke's Regional Medical Center, Aberdeen, secure an "EACH/RPCH" grant of more than $400,000. These grants allow a smaller hospital such as Holy Infant to develop an operating model to reduce its scope of services (i.e., become a "rural primary care hospital," or RPCH) and at the same time establish a working relationship with a larger, tertiary care facility (i.e., with an "essential access community hospital," or EACH). PHS is currently working on an EACH/RPCH grant for Dickey County Memorial Hospital, Ellendale, ND, and St. Luke's.

In return for curtailing their range of services and limiting patients' length of stay to two days, RPCH hospitals are released from some of the conditions for Medicare participation. Without this eased regulatory pressure, Porter explains, many rural communities would be unable to support any kind of hospital.

reimbursement by as much as $3,000 or $4,000 a month," he explains. "In some instances our expertise in coding has enabled hospitals to collect—on a single case—several thousand dollars more than they would have otherwise received."

SHARED SERVICES

Group Purchasing The PHS group purchasing program, called PACE (or Presentation Affiliated Cooperative Effort), is one of the largest Catholic-sponsored purchasing organizations in the United States. Begun in the 1940s as a cooperative effort among four hospitals owned by the Sisters of the PBVM, the program has expanded to include more than 400 participants in 7 states. Richard Thompson, PHS's senior vice president for corporate programs, says the majority of PACE members are small-town hospitals and nursing homes, but clinics and even schools participate as well.

PACE offers discounted purchasing in four major areas:

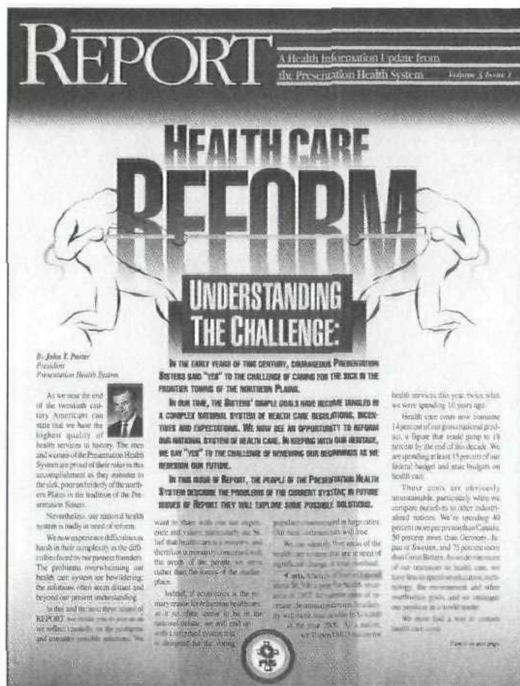
- Medical surgical—used mostly by hospitals
- Pharmaceutical—used by hospitals and clinics
- Dietary—used by hospitals and nursing homes, as well as public school districts and Catholic schools
- Capital equipment—used by hospitals, clinics, and nursing homes

According to Porter, one reason for PACE's growth is that in PHS's predominantly rural service area few other institutions are large and cohesive enough to provide such a service effectively.

Collection Agency In the mid-1980s PHS helped establish an independent debt collection agency, Accounts Management, Inc. (AMI). Created as a joint venture with Sisters of Mary of the Presentation Health Corporation, Fargo, ND, AMI is available to any hospital.

Before AMI was incorporated, AMI manager Brad Adamson explains, PHS hospitals usually turned patient accounts over to regular commercial collection agencies. "Those agencies would charge 30 percent to 50 percent for collections," he says. "In the fiscal year ending in 1991, AMI was able to collect patient accounts for a net cost of about 19 cents on the dollar. In many cases, it cut in half what hospitals had been paying to other collection agencies."

Located in Sioux Falls, AMI has a staff of about 10. All contacts are made by mail or over the telephone. The organization's goal, Adamson says, is to be compassionate yet effective, working with people in structuring realistic approaches to meeting obligations and debt.


REPORT

A Health Information Update from the Presentation Health System

HEALTH CARE REFORM

UNDERSTANDING THE CHALLENGE:

By John F. Porter
President
Presentation Health System

IN THE EARLY YEARS OF THIS CENTURY, COURAGEOUS PRESENTATION SISTERS SAID "YES" TO THE CHALLENGE OF CARING FOR THE SICK IN THE FRONTIER TOWNS OF THE NORTHERN PLAINS.

IN OUR TIME, THE SISTERS' SIMPLE GOALS HAVE BECOME TANGLED IN A COMPLEX NATIONAL SYSTEM OF HEALTH CARE REGULATIONS, INCENTIVES AND EXPECTATIONS. WE NOW SEE AN OPPORTUNITY TO REFORM OUR NATIONAL SYSTEM OF HEALTH CARE. IN KEEPING WITH OUR HERITAGE, WE SAY "YES" TO THE CHALLENGE OF RENEWING OUR BEGINNINGS AS WE REDESIGN OUR FUTURE.

IN THIS ISSUE OF REPORT, THE PEOPLE OF THE PRESENTATION HEALTH SYSTEM DESCRIBE THE PROBLEMS OF THE CURRENT SYSTEM; IN FUTURE ISSUES OF REPORT THEY WILL EXPLORE SOME POSSIBLE SOLUTIONS.

As we near the end of the twentieth century Americans can state that we have the highest quality of health services in history. The men and women of the Presentation Health System are proud of their roles in this accomplishment as they minister to the sick, poor and elderly of the northern Plains in the tradition of the Presentation Sisters.

Nevertheless, our national health system is badly in need of reform.

We now experience difficulties as harsh in their complexity as the difficulties faced by our pioneer founders. The problems overwhelming our health care system are bewildering; the solutions often seem distant and beyond our present understanding.

The latest issue of *Report* explains the need for healthcare reform.

ADVOCACY

As a healthcare leader, PHS's responsibilities go beyond sharing services and expertise. The system is also a political voice for rural healthcare facilities in its region.

Recently, system leaders have been meeting with the South Dakota secretary of health to discuss how they can collaborate to improve healthcare delivery while avoiding duplication of services. In a meeting last January, representatives from PHS and the state department of health focused on concerns about the availability of emergency medical services in South Dakota. "It is important that we keep a dialogue going with the state on such issues," Sr. Collins emphasizes. "Knowing what the government is planning helps us put together our own plan of action. It also gives us a chance to react to and critique the state plan."

One of PHS's most important advocacy tools is *Report*, a quarterly newsletter available to people in the system's service area. *Report* includes articles on key issues in rural healthcare, such as the shortage of nurses and physicians and the growing need for long-term care. The most recent issue, the first of a four-part series on reforming the U.S. healthcare system, provides a variety of perspectives on what is wrong with the

Continued on page 78

Coming in the Next Issue of

Health Progress

HUMAN RESOURCE ISSUES

Today's shortage of healthcare professionals threatens facilities' survival. In the special section, human resource experts describe their institutions' programs for attracting and retaining values-oriented professionals. Regionalization helps one multi-institutional healthcare organization retain employees in member facilities. Another organization uses a nine-step process for finding values-oriented leaders.

CHA'S IMMUNIZATION CAMPAIGN

Barriers to the healthcare system prevent many children from receiving vaccinations. As a result, diseases once thought to have been virtually eradicated are increasing at an alarming rate. CHA's immunization campaign will help Catholic institutions improve vaccination rates in their communities.

CONFRONTING THE TAX-EXEMPTION DEBATE

CHA's Task Force on Tax Exemption encourages CHA members to adopt voluntary community benefit standards as one way to defend their tax-exempt status.

NUTRITIONAL SUPPORT

Continued from page 71

costs stemming from such factors as increased length of stay, increased need of antibiotics, and increased need of ventilators. Ultimately such hospitals run the risk of increased complications and death associated with such failure and attendant risk of malpractice suits or inquiries of supervising bodies on patient outcome.

To avoid such complications and resultant quality-assurance issues, executives must ensure proper parenteral or enteral hyperalimentation protocols are established. Orders should be written by knowledgeable physicians, since patients requiring such therapy are extremely ill and the treatment itself can be complex. The credentials committee should set an objective standard for awarding the clinical privilege of writing complex hyperalimentation orders.

Hyperalimentation therapy itself should not become the reason for continued hospitalization because of inappropriate order writing or medical treatment. If the patient requires nutritional support, it should be provided. When provided, it should be efficacious and safe. □

NOTES

1. G. P. Buzby et al., "Prognostic Nutritional Index in Gastrointestinal Surgery," *American Journal of Surgery*, vol. 139, 1980, p. 160; J. L. Mullen, G. P. Buzby, and D. C. Matthews, "Reduction of Operative Morbidity and Mortality by Combined Preoperative and Postoperative Nutrition Support," *Annals of Surgery*, vol. 192, 1980, p. 604.
2. E. I. Feinstein and M. E. Astiz, "Parenteral Nutrition in Acute Renal Failure," in Mitchell V. Kaminski, Jr., ed., *Hyperalimentation—A Guide for Clinicians*, Marcel Dekker, New York City, 1985; C. B. Mills, "Nutritional Support in Cardiac Disease," in Kaminski; J. Askenazi, C. Weissman, and P. LaSala, "Nutrition for Patients with Respiratory Failure," in Kaminski; Levinsky and A. H. Spiro, "Nutritional Support and the Liver," in *Kaminski*.
3. B. A. Freed et al., "Enteral Hyperalimentation: Frequency of Formula Modification," *Journal of Parenteral and Enteral Nutrition*, vol. 5, no. 1, 1981, pp. 40-45.

RURAL SYSTEM

Continued from page 75

current system. Later issues in the series will explore possible solutions.

The role of *Report*, Porter explains, is to familiarize rural residents with healthcare issues that will likely affect them directly at some point. Porter adds that without public education, meaningful healthcare system reform will be difficult to achieve.

LEADERSHIP DEVELOPMENT

As the challenges to effective rural healthcare delivery mount, providers must constantly seek to strengthen coalitions of care givers and to keep abreast of innovative answers to the problems they face.

In 1990 PHS's Center for Rural Health and Economic Development sponsored its first Invitational Rural Health Leadership Conference for administrators, trustees, and communicators associated with system hospitals. The conference focused on external forces and trends affecting rural healthcare delivery. The 1991 conference, titled "Health Care in Main Street: Joint Partnerships," featured three speakers who described successful healthcare and self-development projects. The third annual conference, "Breaking Through: The Real Meaning of Change and Transition in Rural Healthcare," will be held this October. Sr. Collins explains that the conference will explore the barriers leaders and communities face in making the transition to new forms of healthcare delivery and ways to increase access to care.

Porter says that the conferences, which bring together civic and healthcare leaders, reaffirm PHS's commitment to the region it serves. "We cannot expect to strengthen rural healthcare," he concludes, "without strengthening the economic and social fabric of our rural communities." *—Phil Rheinecker*