JANUARY 2009 ORH NEWSLETTER

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2009—A New Year—A New Opportunity in Rural Health

FLEX WEBEX LEARNING SERIES

The ORH and the Flex Program are excited about this year's Flex WebEx Learning Series. **These sessions are at 12 PM (Pacific) on the first Tuesday of every month – and you never have to leave your office!!!** The series uses WebEx so you can get the benefit of a conference without all the hassle! The sessions are a great opportunity to learn from leaders and colleagues about the different issue facing Critical Access Hospitals and other rural providers - quality initiatives, cost reports, capital finance, patient safety, balanced scorecard and other interesting topics.

Click here to see the schedule and learn how you can participate!

MARK YOUR CALENDARS!!! NOVEMBER 5 – 7, 2009

Oregon Rural Health Conference
Salishan, Gleneden Beach, OR
Watch for Details—This is one conference you won't want to miss!

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CMS RURAL OPEN DOOR FORUM – WEDNESDAY, JANUARY 28

The next Rural Health Open Door Forum (ODF) is scheduled for Wednesday, Jan. 28, at 11:30 a.m., EST. This month's call will be held in conjunction with NRHA's Rural Health Policy Institute in Washington, D.C., and conference attendees are welcome to join CMS in the room for the call. The call allows rural health facilities and practitioners to question CMS directly on reimbursement questions.

To participate by phone, the participation information is: 1-800-837-1935, conference ID 70013728.

For more information on the Rural Health Policy Institute, visit **www.RuralHealthWeb.org/pi**.

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THE OREGON TOOTH TAXI—WORKING FOR BRIGHTER SMILES!

In partnership with OEA Choice Trust and the ODS Companies, The Dental Foundation of Oregon's Tooth Tax has hit the road. The Dental Foundation of Oregon (DFO), concerned about Oregon's high rate of dental decay and lack of access to dental care, has worked for over three years to make the Tooth Taxi a reality.

The Tooth Taxi is more than just a yellow car—in fact, it is not a car at all. It is a state of the art, mobile health clinic that travels to schools to provide direct dental care and oral health education to thousands of children throughout Oregon. After a presentation by Mary Daly, Program Director for the Tooth Taxi, Scott Ekblad, Director of the ORH, said, "What they are doing in amazing. The need for dental services in Oregon is so great and they have jumped right in to help address the issue." 22 of Oregon's 36 counties have a shortage of dental professionals.

And what has happened since the Tooth Taxi was unveiled on August 27, 2007? According to Mary Daly, great success. As of December 2008:

Total Students Screened:	600
Total Students receiving oral hygiene education in class:	300
Total Students treated on the van:	300
Total value of free dental services:	$188,000

And 2009 won't be a quiet year. The Foundation has already announced its busy schedule for the year. But it won't succeed without your help. If you want to be a part of the Tooth Taxi, call or email Mary Daly at the Dental Foundation of Oregon.

Find out more information by going to **http://www.smileonoregon.org/publications/index.shtml**.

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NATIONAL RURAL HEALTH ASSOCIATION (NRHA) CONTINUES WORK WITH OBAMA TRANSITION TEAM

On December 16, NRHA government affairs staff had a formal meeting with members of the Obama Health Policy Transition Team in Washington, D.C. During the meeting, NRHA staff shared the association's desire to see the incoming administration focus on rural health as part of any major reform of the health care system and not simply as an addendum. In addition, NRHA provided the health policy staff a **series of items** that could be dealt with immediately upon assuming office to help deal with payment inequities, looming workforce crises in rural America and physical infrastructure needs.

The meeting comes on the heels of numerous informal conversations between NRHA staff and members of the Obama Transition Agency Review Teams for the Department of Health and Human Services, the Health Resources and Services Administration, the US Department of Agriculture and the Centers for Medicare and Medicaid Services. NRHA staff will be following up over the next couple weeks with these contacts and posting additional materials on their web site.

Later this month, the transition teams will give way to the new administration on January 20, when President-elect Barack Obama is inaugurated in Washington, D.C. Key members of the president-elect's cabinet have been selected, and we expect confirmation hearings for Health and Human Services Secretary-designate Tom Daschle to begin this month. As these hearings happen and as the new team takes their places, NRHA staff will be working to assure the rural voice is heard by these key officials and that they understand the unique challenges of rural health.

Lisa Dodson, MD, outgoing president of the **Oregon Rural Health Association,** (ORHA) says these contacts are important for Oregon. "The President-elect has made health care a priority and we cannot fix our system if we do not address the challenges facing rural health. The ORHA will be working closely with the NRHA and our federal delegation to keep the attention on the needs of rural Oregon."

During the campaign, Obama made health reform a top priority and responded to an **NRHA questionnaire** demonstrating his commitment and understanding of the unique needs of the rural health system. His transition teams have made clear that the president-elect is committed to improving the health of millions of rural residents. NRHA staff will continue to work with these transition teams and the incoming administration to assure that these commitments are kept and that the Obama Administration makes significant improvements for rural America.

http://newsmanager.commpartners.com/nrha/issues/2009-01-06/2.html

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READY OR NOT, HERE COME THE RACS

John Commins, for HealthLeaders Media, January 7, 2009

Like the smothering Vandal horde that plagued Europe nearly two millennia past, recovery audit contractors will soon swoop down on your hospital, thumb through your records, slosh coffee rings on the paperwork, and pore through every Medicare bill you've filed in the past few years, hoping to earn a commission of between 12 cents and 15 cents for every dollar they find that you've allegedly overcharged the feds.

OK. I hyperbolize. Not all RACs drink coffee.

The fact remains, RACs are coming—if not this year, then next year as the pilot program expands beyond the test states of New York, Florida, and California. And they will be authorized to look through your Medicare filings with a start date of Oct. 1, 2007.

Are you ready?

John Dugan, a consultant for the Health Industries Sector at PriceWaterhouseCoopers, has worked with hospitals involved in the RAC pilot program, and he recommends having a strong multidisciplinary team in place to deal with records requests and challenges.

"We believe there should be an organized RAC committee in each hospital with one individual on point for the organization," Dugan says. That team typically includes representatives from finance, compliance legal, case management, health information management, and a physician liaison. It might be a little tougher for smaller hospitals to assemble such a team or add new staff, Dugan concedes, which may mean an increased workload for existing management.

RACs are permitted to select up to 200 records every 45 days for an inpatient hospital. "You have a tremendous amount of volume coming through and data-gathering that needs to be produced to make sure you are filing on a timely basis," Dugan says. And with a strong multidisciplinary team in place "you've got the perfect protocol to handle appeals successfully," he says.

Many challenges to Medicare billing fall in the gray areas of medical necessity and medical judgment, and Dugan says that's why it's imperative to have a physician on your team who understands the particular medical issue under scrutiny, a case management officer who understands your hospital's quality policies, and a finance officer who understands the reimbursement impact associated with an adjustment. "When we say 'multidisciplinary,' we mean don't make the mistake of putting in one person's hands what a team should be doing so you are getting the best outcomes," says Dugan, who also recommends building a control mechanism to deal with RAC records requests.

Hospitals should also understand their potential reserve requirements and establish a fund for Medicare overpayments. This is tricky, both in terms of finding money for a reserve fund and determining the appropriate amount. If a hospital proactively attempts to understand its potential liability through a self-audit, for example, that hospital then becomes liable — under the False Claims Act —for overpayments it finds. That also opens the door for a deeper RAC audit.

"It's a tough balance from running a limited sample to understand processes, to doing something significant and having a high enough error rate that you've got bigger obligations that are beyond those claims you just looked at," Dugan says. "Hospitals need to think through their objectives for managing risk. You don't want to examine the records, have your findings, and then say 'Oh, what did we do!'"

Rather than delving too deeply into the past, which can't be corrected and which the RACs will probably find anyway, Dugan recommends focusing on the present and reviewing internal controls that are now in place around risk areas. "If I'm a CFO, I want to mitigate my risk, but I don't necessarily want to turn over money to the government that I wasn't necessarily obligated to do previously," he says. "If I'm focusing on short-stay admission, maybe I don't want to look at medical records. What I may want to do is look at my current processes and internal controls and strengthen them going forward."

If you don't have the time, data, or resources to estimate the value of your reserve fund, Dugan suggests an amount representing 2% of Medicare revenues, which he concedes is still a lot of money, especially in these tough economic times.

As arduous as the RAC process may be for larger facilities, Dugan says it could be even tougher for community and rural hospitals, both in terms of resources constraints and financial pressures. Small hospitals may not have the extra bodies needed to throw at a RAC review, and they definitely don't have the operating margins. In addition, Medicare usually makes up a larger percentage of the patient load in smaller and rural hospitals, where fewer treatment options could also raise red flags about medical necessity. "If you've got a patient who shows up at the ED on Friday night without a primary-care physician and no processes in place or other alternatives, that patient will likely be admitted," Dugan says. "It will be interesting to see if the RAC treats this group of hospitals any differently."

John Commins is the human resources and community and rural hospitals editor with HealthLeaders

Media. He can be reached at **jcommins@healthleadersmedia.com**.

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SHAPING GOOD HEALTH AS TEENS OUTGROW PEDIATRICIAN

By Lauran Neergaard, AP Medical Writer

Ever watched a teen skulk in the corner of a toddler-packed pediatrician's waiting room, obviously wishing to be anywhere else?

Adolescents aren't just big kids, and too many start falling through cracks in the health care system when they pass the stage of preschool shots and summer camp checkups — what a major new report calls missed opportunities to shape the next generation's well-being.

The period between ages 10 and 19 is unique, bringing more rapid biological changes than perhaps any age other than infancy. Even though most of the nation's 42 million adolescents seem to be thriving, it is a time of risk-taking and pushing boundaries in ways that can mean immediate consequences: Car crashes, experimenting with alcohol or drugs, teen pregnancy, sexually transmitted disease.

And it's also an age when many of the habits that determine good health during adulthood are set, or not.

"They are quite literally our future. If we don't take good care of them, there's a strong likelihood when they're running the ship they're not going to have a good time running the ship," said Dr. Frank Biro of Cincinnati Children's Hospital's long-running adolescent medicine program.

Yet the system of care for tweens and teens is fragmented and poorly designed. Few doctors specialize in adolescents' complex needs, or provide comprehensive care that earns their trust, concludes a recent probe by the National Research Council and Institute of Medicine. Most at risk are the poor.

The result: The past decade has brought declines in teen pregnancy and smoking but little other overarching progress. Tweens and teens increasingly are overweight; physical activity's dropping; chronic diseases like asthma and diabetes are on the rise; and injuries, chiefly from car crashes, remain this age's leading cause of death.

While 20-somethings tend to see primary-care doctors the least, a gradual falloff begins in adolescence. Only a fraction of tweens and teens have been screened for risky behavior so doctors can intervene before a problem arises, the report found. Between 10 percent and 20 percent of adolescents annually experience a mental health disorder, such as depression or anxiety, with less access to that specialty care. Five million are uninsured, too often even left out of federal-state programs designed to provide health coverage to children.

Yet half of deaths among adults are due to health-related behaviors that often start during adolescence.

"A 10-year-old is probably the healthiest person in America," notes Dr. Frederick Rivara of the University of Washington, a co-author of the new report. "Something happens between age 10 and age 25."

Teens do tend to see a doctor, clinic or school-based care program somewhat regularly, if not because parents demand it, then for vaccinations or the 15-minute physical required by sports teams. But the report notes it can take at least 40 minutes to do a thorough adolescent checkup, including screening and counseling for risky behaviors — the kind that may prompt enough trust for the teen to return with a problem he or she doesn't want Mom to know about.

But with fewer than 500 doctors certified as adolescent medicine specialists between 1996 and 2005 — some states have none — most families will need to hunt a pediatrician or family physician with the communication and social skills and, perhaps more importantly, the true interest to engage a teen.

"Adolescents have so much energy. They see the world so differently than you or I," says Biro, Cincinnati's adolescent medicine chief, who wasn't part of the report and says society's stereotype of sex and drugs isn't the typical teen.

The relationship starts with the doctor making clear that the adolescent has a right to patient confidentiality that grows with age, although he or she must work with the parents, too.

As Biro describes the balancing act: "As long as you're not hurting yourself, another person or getting hurt

by another person, I will hold that information confidential. ... If there's a direct health risk that could involve their life, then I will share that."

Then comes recognizing that the early teen years are when kids move from concrete thinking to more abstract thought — they begin to connect the dots, Biro explains. They may assume the doctor connected the dots the same way, meaning a girl who complains of stomach pain may not volunteer that she's fears pregnancy.

"It's not that they're withholding information. They figure they've just told you everything you need to know because the rest of it you should be able to figure out," Biro says. "I prove to them I am indeed about as smart as mud and I have to ask them more probing questions."

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HEALTH CARE SURVEY ILLUSTRATES FINANCIAL HARDSHIP

The Center for Rural Affairs has written extensively about the health care challenges faced by rural small businesses, including farmers and ranchers. Their report Health Care in Rural America (**http://www.cfra.org/policy/health-care**) speaks in detail about farm and ranch families' dependence on a system that is very expensive and provides minimal coverage.

Now a new health insurance survey of farmers and ranchers corroborates the financial hardships that accompany rising health care costs.

The Access Project has released Who Experiences Financial Hardship Because of Health Care Costs?, part of a series detailing results from a 2007 health insurance survey of farm and ranch operators, a survey of over 2,000 non-corporate farmers and ranchers in Iowa, Minnesota, Missouri, Montana, Nebraska, North Dakota and South Dakota.

Using two commonly accepted measures of financial hardship caused by health care costs – 10 percent or more of household income spent on insurance premiums or out-of-pocket medical costs, and a self-reported perception that health care costs contribute to a household's financial problems – the report finds:

- 44 percent of households spent more than 10 percent of their income on health insurance premiums and additional out-of-pocket medical expenses. For those who said farming or ranching was their principal occupation, the figure rose to 54 percent.
- Those that purchase private, non-group insurance are more at risk of spending 10 percent or more on health care costs.
- Those that purchase health insurance in the private market spend twice as much on premiums and out-of-pocket costs as those who obtain insurance through off-farm or ranch employment.
- Nearly a quarter of households reported that health care costs contributed to financial problems; again, the figure is higher for those who report farming or ranching as their principal occupation.
- Households that reported health care-related financial problems spent an average of 42 percent of their income on health insurance premiums and out-of-pocket costs.
- Significant numbers of those reporting health care-related financial problems said health care costs caused them to delay making improvements on the farm or ranch and that health care costs made it harder to pay off farm or ranch loans.

Health care costs also have serious long-term consequences for farm and ranch families. Over a quarter of all responding households stated they had to draw on family resources and assets to pay health care costs. The largest resources used were family savings, credit cards and bank loans, but significant numbers withdrew funds from retirement accounts or borrowed against the farm or ranch. Whatever the source, many families are using important assets or incurring larger debt to pay for basic health care needs and placing their financial futures at risk.

These findings reflect many of the unique health care challenges faced by rural people. As the new Congress and new administration prepare to debate reforming the nation's health care system, together we must educate our policymakers on the need to devise a health care system that works for all.

The Access Project reports may be found at **www.accessproject.org**

Contact: Jon Bailey, **jonb@cfra.org** or 402.687.2103 x 1013 for more information.

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IS LIVING IN A CITY MORE DANGEROUS THAN LIVING IN A RURAL AREA?

Maybe not.

Writing in the January issue of The American Journal of Preventive Medicine, researchers report that there is a much higher rate of hospitalization for most kinds of accidental injury in rural areas than in cities. But the rate of injuries from assaults is significantly higher in urban areas.

In the largest urban neighborhoods, the injury-hospitalization rate is 610 per 100,000, compared with 826 per 100,000 in the smallest rural areas, with rural car accidents contributing disproportionately to the difference. Learn more by going to **http://www.ajpm-online.net/article/S0749-3797(08)00836-2/abstract**.

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GLOBAL HEALTH WEBSITE ADDS NEW COUNTRY-LEVEL DATA

GlobalHealthFacts.org this week added 12 new health-related indicators and updated more than 50 others across a wide range of areas and topics. New data include Global Fund disbursements by type of grant; malaria cases and deaths; prevalence of obesity; as well as polio cases and immunization coverage. The site provides up-to-date and easy-to-access country-level data on HIV/AIDS, tuberculosis, malaria and other global health conditions; demographics and economics; health systems; and health program funding and financing.

The Global Health Website can be viewed at **http://www.globalhealthfacts.org/index.jsp**.

UPCOMING EVENTS

A complete listing of upcoming events can be at **http://www.ohsu.edu/oregonruralhealth/events/**.

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