Rural Wisconsin
Health Cooperative

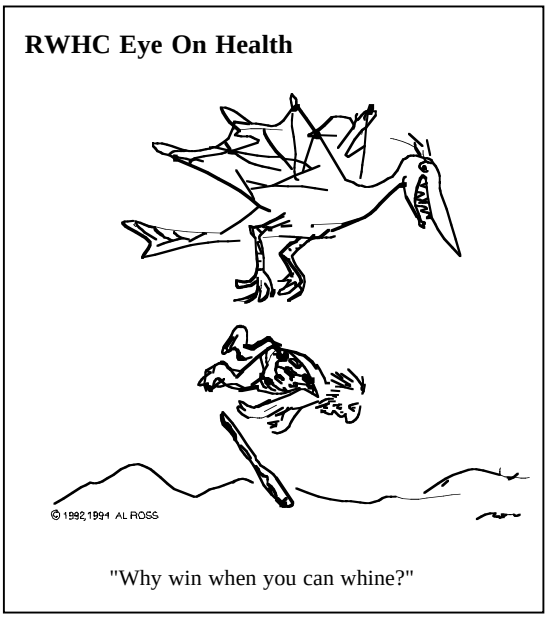
Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective - December 1st, 2002

New Road To Rural Political Effectiveness?

From "Making Friends in the City" by Thomas D. Rowley, one of a series of on-line commentaries (www.rupri.org, posted 11/11/02) intended to help further the Rural Policy Research's mission to "facilitate" public dialogue concerning the impacts of public policy on rural people and places:

"To build a truly effective constituency for rural policy, we're going to have to bring in not just our natural rural allies, but also our urban and suburban friends. They do, after all, outnumber rural folks four to one and have more money to boot. So, what city folks think about rural America, what they want for it and from it, carries a lot of weight in the halls of government as well as the marketplace—more weight sometimes than what rural folks think and want. We'd better have them in our camp."



"Why win when you can whine?"

"Some folks will bristle at that suggestion owing to long-held mistrust of, and distaste for, city folks and city ways. Some will be tempted to say that rural America (red America in the famous map showing which parts of the country voted for Bush and which parts for Gore) elected the President; that he's ours and we're his."

"These objections have one thing in common: they both look backward. Rural America, if it is to thrive, if it is to do anything other than wax nostalgic, must look forward. Yes, there is a history of exploitation. What can be done to turn that into collaboration? Yes, this administration came in largely on the rural vote. What has that gotten us? More importantly, what about the next administration, and the next? It will take that long to build an effective constituency. We'd better get started."

"The question, of course, is 'how'? On what basis can a rural-suburban-urban coalition be built, and how should these new partners be approached?"

"To connect with urbanites, the basis might well be poverty. Rural and central-city poverty have a lot in common. They disproportionately hit people of color, single moms and their children. They are geographically concentrated, resulting in ghettos. And they lead to the same consequences: teen pregnancy, substance abuse, educational failure, and worst of all despair."

"To connect with suburbanites, the basis could be sprawl and/or the protection of rural amenities—wilderness, small towns, environmental quality—that both groups care about. If Willie Nelson and Farm Aid can connect with people whose only connection to agriculture is, to quote Jim Hightower, 'eating', why can't we connect to them on the broader concerns of rural America?"

"In fact, I believe we can, if we find the right pitch. The wrong pitch, the one that bounces in the dirt five

feet from the plate, is the recitation of rural ills, the 'rural whine' as some call it. Sandy Rosenblith is Senior Vice President of the Rural Local Initiatives Support Coalition, co-sponsor of the rural public relations campaign, *Stand Up for Rural America*. She puts it this way, 'No one wants to help where there is no hope.' "

"An equally bad pitch is 'we're better than you.' Saying that rural America deserves help because it is the backbone of the nation, the last bastion of morality, or, as Teddy Roosevelt's Country Life Commission penned, 'the stay and strength of the Nation in time of war, and its guiding and controlling spirit in time of peace' isn't such a hot idea. Self-righteous proclamations—especially while holding a cup out—fall on deaf if not hostile ears. Backlash over the Farm Bill has only increased that hostility."

"So what's the right pitch? I honestly don't know. I do, however, think it has several elements. It shows how everyone will benefit from a revitalized rural America. It eliminates the 'us versus them' mentality. It appeals to both the head and the heart. And it offers hope."

"It offers hope, because there is reason to hope. Indeed, the urban-rural divide is being bridged in a number of places. People from both sides of the city-limit sign are coming together to fix problems that do not respect such signs. Why?"

"Kentucky author and philosopher, Wendell Berry sums it well:

> Why this interest in 'linkages between urban and rural citizens' that has been growing in our state, and in the nation, over the past several years? I think it is because urban and rural people have begun to realize that they share the same land, and therefore the same fate. I think they have begun to realize that to divide the human community up into 'competing interests' finally doesn't work because finally it is a false version of reality."

A Champion For Medicare Equity

From "A big job for Grassley, as chairman of Finance again, he can help fix Medicare's shortchanging of Iowa" in the *DesMoines Register*, 11/07/02:

"The issue was a candidate's dream: Iowa is dead last in Medicare reimbursements. The injustice of it all lends itself to equal-opportunity outrage. All the candidates vowed that, if elected, they would work hard to change the Medicare payment system. Everyone was for fairness. Everyone was for getting Iowans what they deserve."

"The complicated government formula that results in Iowa receiving the lowest Medicare reimbursement was created by Congress. The result has been that Medicare pays an average of $3,053 a year per beneficiary in this state. (*Wisconsin is 15th from bottom at $4,500 in the FY 2000 data used for this report.)* The national average is $5,490. Louisiana tops the list, receiving more than $7,000. The difference between what Iowa receives and the national average adds up to this state losing $1 billion a year. Without that money, Iowans also lose options in medical care, economic opportunities, higher salaries for health-care workers and access to care in rural areas."

"The problem created by Congress must be fixed by Congress. They're familiar with the problem and what's needed to fix it. An interesting twist in the national election that gave Republicans control of the U.S. Senate could work to Iowa's advantage on this

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.

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issue. Now Senator Chuck Grassley of Iowa will once again chair the Senate Finance Committee, which writes the laws on Medicare."

"For Iowa, Medicare reimbursement is the biggest issue. An aide to Grassley acknowledged this when he said, 'The equity issue has grown in importance to the senator, as it has to Iowans.' Now, Grassley can once again wield his influence to push for a plan that delivers fairness to this state."

Focus On Quality Could Bring Bonus

From "Higher Fees For Better Health Care Proposed" by Robert Pear; this is the *Milwaukee Journal Sentinel* version of a story in the *New York Times*, both appearing on Oct. 31, 2002. Joe Manning of the *Journal Sentinel* staff contributed to the report:

"The National Academy of Sciences has said that Medicare, Medicaid and other government programs should reward high-quality health care by paying higher fees or bonuses to the best doctors, hospitals, nursing homes and health maintenance organizations. In a report requested by Congress, the academy said that the federal government should establish standard measures of quality, assess the performance of each health care provider and publish comparative data for use by consumers."

"The possibility of an increase in the amount of reimbursements paid by federal government programs potentially could help Wisconsin solve one of its biggest and most enduring health care cost problems - an annual $1 billion Medicare shortfall."

"Hospital, health insurance and state officials have estimated that the under-reimbursement in the federal health insurance program for the elderly is a major reason why Wisconsin—and particularly southeastern Wisconsin—has higher health care costs than other parts of the Midwest."

"Medicare shortfalls are passed on to commercial health insurance companies in the form of higher prices and result in inflated health insurance premiums paid by businesses and employees."

"A federal system based on rewarding quality could be a means of getting around the Medicare reimbursement formula without having to continually wage congressional battles with states that would stand to lose money in a quality-directed award system."

"But the National Academy of Sciences report focuses more on quality of care than making reimbursements more equitable. 'The federal government should take full advantage of its influential position to set the quality standard for the entire health care sector,' said Gilbert S. Omenn, chairman of the 17-member panel that issued the report."

"One way to do this, Omenn said, is to link pay to performance. Health care providers achieving 'exemplary levels of performance,' as measured by government criteria, might receive 5% to 15% more than the standard payments, the panel said."

Health Care Consumerism—The Next Wave?

From "Consumer-Centered Health Care: A New And Promising Model?" by Chris Queram, in the *Wisconsin Academy Review*, Fall, '02. Access full article at:

www.alliancehealthcoop.com/news/CQ_CCHBP.pdf

"While the forces driving employers to adopt a new strategy are clear, there is no single form that a 'consumer-centered' health care system will take. Rather than one model, there will likely be a variety of approaches, all of which will embody the following design principles:

- Employees will be asked to assume increased responsibility for decision-making in terms of the health care services they choose to receive, the caregivers who provide the services, and the cost of these services;
- Employees will be given financial incentives to seek appropriate care, both preventive and acute;
- Employees will be given web-enabled decision support tools, with an emphasis on increased

transparency of differences in the cost and quality of local health care providers; and

- Hospitals and clinics will be required to provide increased disclosure and transparency of variations in both the price and quality of services they provide."

"Under this approach, an employer would make an annual contribution to each employee's 'personal care account'; the amount would vary based on whether the employee is single, married, and/or providing coverage for dependents. The employee would have the ability to choose from an array of providers from whom to receive health care services. The employee would manage the choice of when and from whom to receive health care; however, unlike the traditional model of insurance, the cost of routine services as well as coinsurance and deductibles is drawn from the employee's 'personal care account.' "

"Any funds left over at the end of a plan year would roll over to the next, creating the potential for the fund to grow over time. In addition, the employer would provide a major medical plan to ensure coverage for more significant needs such as hospitalization. And the employee would be provided with incentives to make wise choices on preventive services, along with cost and quality information on the health care providers in the local community."

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"Tough choice; do we call the new health insurance 'consumer centered health care' or 'employer shifts the risk.' "

"Admittedly, the concept of 'defined contribution' health care is in its infancy, and the employers around the country who have adopted this model have not yet had sufficient time to gauge its true potential. Care must be exercised so that consumers of all ages and health status are encouraged to participate, thus minimizing the risk that only the young and healthy enroll ('adverse selection'); and information on differences in the price and quality of health care providers must be accessible and comprehensible to people of all levels of income, education, and literacy."

"Nonetheless, the intuitive appeal is motivating many more employers to examine the concept and, barring a sudden return to a more favorable cost trend, the likelihood of increased adoption is high. In fact, some predictions suggest that as many as 20 to 30 percent of all employer-sponsored health care coverage will be under a 'defined contribution' model by the end of 2003."

Editor's Note

For additional reading go to "Consumer-Driven Health Plans: Are They More Than Talk Now?" at <http://www.healthaffairs.org>: "With an estimated enrollment of 1.5 million, health plans that allow consumers to customize their benefits and provider networks could comprise 15-50 percent of the market in five years. But the article warns that such 'consumer-driven' health plans need to be watched closely to see if the added choices and greater emphasis on consumer spending disincentives appeal broadly to employees and enrollment grows; or if, as some predict, consumer-driven health plans split up risk pools and shift costs to sicker enrollees."

Regional Maternity QI Collaboration

RWHC Hospitals are strongly committed to providing high quality maternity care. To that end, 16 member hospitals initiated a project this summer called "Measuring Local Maternity Outcomes & Developing Capacity for Improvement" with major funding from the Employer Health Care Alliance Cooperative (The Alliance) Provider Quality Investment

Fund based in Madison, Wisconsin. (Eleven of the participants are Alliance providers.)

On behalf of these facilities, RWHC is proposing a project with a focus on labor and delivery in community hospitals. This multi-hospital collaboration addresses that need in the manner most effective for rural communities.

The three objectives for this initiative emphasize project planning and QI strategic development. They are: (1) to reach consensus on a common set of maternity care quality measures based on clinical data sets, (2) to determine, through chart reviews, the degree to which each hospital is achieving those measures and (3) to formulate specific QI strategies based on these findings.

RWHC has engaged two consultants to assist us with the project. Dr. William Hueston is the Chair of the Department of Family Medicine at the Medical University of South Carolina. He recently served as a panelist on the NCQA/AMA/JCAHO collaborative panel to examine health quality for maternity and newborn care. Previously, he was the residency director of the Eau Claire Family Practice Residency in Eau Claire. While at Eau Claire he conducted a multi-site study of pre-term labor evaluation and management in a group of rural and small towns in Western Wisconsin.

Patricia Stone, PhD, MPH, RN, is an Assistant Professor of Nursing, Program Director of Advanced Clinical Management at Columbia University, School of Nursing in New York. Dr. Stone is also a funded AHRQ patient safety researcher. She received her PhD at the University of Rochester with her dissertation focused on Models of Prenatal and Childbirth Care. She has several publications including "Outcome Measures of Cost and Quality: Comparing Different Provider Models of Care" and "Improving Outcomes of LBW (Low Birth Weight) Premature Infants and Mothers".

In addition to these two out of state consultants, Dr. Susan Davidson from Madison, Wisconsin, has agreed to review and provide feedback during the process of choosing the outcome measures and reviewing the findings and recommendations of the study. Dr. Davidson is currently the Director of Perinatology at St. Marys Hospital Medical Center. She also serves on the Board of Directors for the Wisconsin Association of Perinatal Care, the External Advisory Committee for the Wisconsin Taratogen Project, and the Scientific Review Committee for both the Perinatal Foundation and the Dean Foundation. She has worked with several RWHC facilities on other projects over the past several years and is quite familiar with the practices in our smaller facilities.

With assistance from Drs. Hueston and Stone, participating hospitals have developed a list of eight measures, with a priority ranking. It was agreed that the top three measures would be used for this initiative, as well as one baseline measure that could be used for future quality improvement monitoring. The top three measures and the baseline measure are now under refinement and physicians from the participating hospitals have been asked to review the measures with the opportunity for them to express any questions or concerns they may have with the measures.

The draft quality indicator measures are as follows:

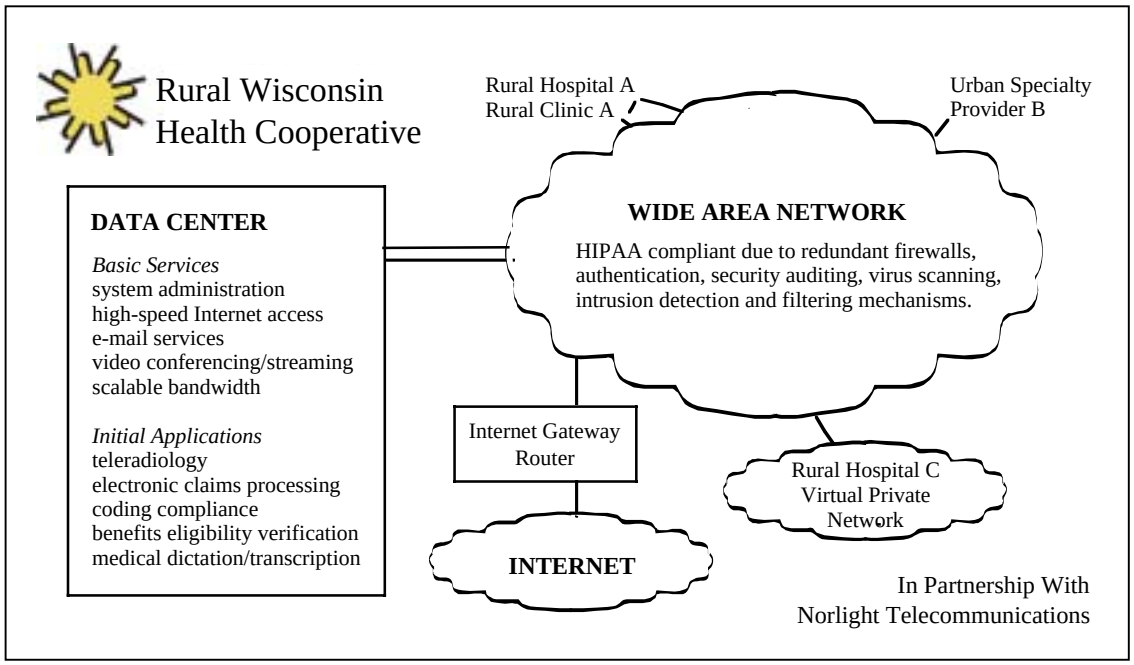
- Appropriate pre-delivery management of Group B streptococcal colonized women (baseline measure only)
- Cesarean sections for dystocia
- Induction of labor for approved indications
- Symptomatic post-partum hemorrhage

Data abstraction and formulation of quality improvement strategies by the participants, as appropriate based on the study, is expected to be concluded by this May.

RWHC Wide Area Network and Data Center

In the past six months, RWHC has made significant progress implementing a wide area network (WAN) that is attracting a lot of attention from rural providers throughout the state. Over 25 hospitals, clinics, regional providers and applications vendors are accessing the RWHC WAN via virtual private networks

(VPNs) or partial/full frame relay connections. This allows them to share hardware, software and infrastructure as they collaborate on a wide range of business or clinical applications designed to reduce expenses across the board. While most connections pass through the RWHC Data Center/firewall, private connections can be established between existing partners.



The original impetus for this endeavor stems from the significant challenges rural providers face when trying to implement large-scale, systemic IT projects. These can include cultural, organizational and financial barriers. It was agreed that if there is one area where collaboration makes sense, it is in the ever-changing arena of information technology. In fact, the RWHC Board of Directors identified IT/telecommunications enhancements as their highest priority during their most recent strategic planning retreat.

By pooling resources and partnering with an established, regional telecommunications carrier (Norlight Telecommunications), RWHC has been able to create a particularly robust frame relay network. This WAN infrastructure permits very high performance as well as secure connectivity. The entire system is totally HIPAA compliant due to redundant firewalls, authentication, security auditing, virus scanning, intrusion detection and filtering mechanisms. Centralized administration and 24/7 technical support is available through Norlight and the network data center, which is housed in the RWHC Office.

Most of the early adopters of this concept were attracted to the "basic services" available through the network, including: high-speed Internet access, e-mail services, video conferencing/streaming, and scalable bandwidth for internal use. Since then the attention has focused on the shared applications which should all be operational before the end of the year. They include: teleradiology, electronic claims processing, coding compliance, benefits eligibility verification, and medical dictation/transcription. In addition, RWHC is exploring partnerships/funding opportunities through the National Library of Medicine and the Wisconsin Area Health Education Centers to develop a shared electronic medical reference library in 2003. RWHC has also hired a full-time network administrator who is managing the WAN and consulting with rural providers on a number of other IT-related issues.

The development and implementation of this project has benefited significantly from private and public sector grant funding from a number of sources, including universal service funding through the Federal Communications Commission (FCC) for individual rural health care providers. Future growth and sustainability will depend on a combination of grants and contributions from participants (after they have realized cost savings through the shared applications). Ultimately, the goal is to assist rural providers to leverage limited resources so they can reduce IT/networking expenses and perform at a very high level.

Footnote: RWHC has appealed to the FCC a decision by the Rural Health Care Division of the Universal Service Administrative Company that RWHC is

not eligibility for Universal Service Support. RWHC asserts that as a consortia of health care providers consisting of not-for-profit hospitals (category "(v)"), it is an eligible "health care provider" for purposes of 47 U.S.C. § 254(h)(5)(B) as reiterated in FCC 97-157 (rel. May 8, 1997), Section 653 and FCC 02-122 (rel. April 19, 2002), Section 6. See also, 47 CFR § 54.601(a). A copy of the appeal is available at <www.rwhc.com>.

Work To Do While Debating Medicare

From "Getting The Elderly Their Due, *An HMO executive's firsthand view of poor seniors' helplessness in navigating the U.S. health care labyrinth*" by David Carliner in the Narrative Matters section of *HealthAffairs*, Nov-Dec/02:

"It was a typical call. 'Please come over and help me go through my papers.' Mrs. Smith complains that she does not understand why she gets so much mail 'about the doctors.' We promise our members a single place to call for questions, so we respond."

"Our Baltimore-based organization, a for-profit Medicare HMO, assists elderly people—overwhelmingly poor and female—in applying for governmental health insurance programs. I accompany a colleague from our sales staff to Mrs. Smith's apartment as part of a program to give senior leaders the chance to witness what other team members do and to see firsthand the impact of our work on an individual level. On a more typical day I sit at my desk, far from the reality of our members' lives, engaged in policy and administrative tasks."

"Mrs. Smith (not her real name) meets us at the front door, anxiously awaiting our arrival. We enter her two-room apartment, a combination kitchen/dining room/living room with a separate bedroom and bath. It is quite neat and orderly. We sit at a card table that is covered in papers, grouped and bound by large paper clips and then further aggregated and wrapped in rubber bands. The apparent compulsive organization is a ruse. Medicare Explanation of Benefits forms are mixed in with bills for supplemental policies, housing notices, information from Social Security, from Medicaid—the list goes on. There is no apparent rationale to how the documents are organized; some are current, others decades old."

"We ask a few questions. With each response, we realize that Mrs. Smith does not understand what coverage she has or the programs for which she is eligible but not enrolled in. So we turn to the tangled mess of records to solve the mystery. Like detectives, we look for clues. After considerable study, we have it wrapped. Mrs. Smith's sole source of income is a monthly Social Security check of $574.27. She has a small bank account with less than $2,000 in it and no other assets to speak of. Somehow for ten years or more she has been paying $150 a month for a Medicare supplemental policy that covers Medicare's deductibles and co-payments."

"However, she appears to be eligible for the Qualified Medicare Beneficiary (QMB) program—a Medicaid program that pays for Medicare premiums and high co-pays. Medicare by itself pays for less than 60 percent of total medical costs for a typical beneficiary like Mrs. Smith, making supplemental coverage essential for the poor elderly. QMB, in effect, foots the bill for all of the items covered by her supplemental policy. Like many of her several million peers nationwide, Mrs. Smith is not aware that such a program exists and that it is free. We explain to her that she does not need the Medicare supplemental policy and that she has been wasting $150 a month."

"But the story gets worse. Mrs. Smith hasn't been taking her medicines for several months because she

needs money for food. Drugs (which Medicare does not cover) also are not covered under her supplemental policy. She could have been using the 'wasted' money from that policy for needed medications. Better yet, she is eligible for a state-run drug assistance program that provides prescriptions for a mere $3 copayment (Maryland is one of many states that offer some sort of drug coverage for people like Mrs. Smith). Coverage is free to all who are eligible, but, as for the QMB program, most people don't know they are eligible. Mrs. Smith, like many of our Medicare clients, is dually eligible because her low income qualifies her for Medicaid's QMB program."

"Some 6.7 million Americans are enrolled in both Medicare and some form of Medicaid. But a General Accounting Office report published in April 1999 found that 43 percent of all Medicare beneficiaries who are eligible for Medicare savings programs are not aware of these programs. A small percentage of these people elect not to obtain Medicaid coverage because of the welfare stigma. However, the vast majority of unenrolled-but-eligible persons simply do not know that the program exists or are intimidated by the application process."

"Action plan for Mrs. Smith: Terminate supplemental coverage immediately. Apply for the QMB and state pharmacy assistance programs. In forty-five minutes we developed a plan to eliminate the $150 a month expense for the supplemental policy and put in motion plans to replace that coverage with free coverage and to get Mrs. Smith coverage for prescription medications."

"One noteworthy private effort to help seniors understand the public programs for which they are eligible is a Web site created by the National Council on the Aging: www.benefitscheckup.org.

"Initiatives such as this are a good first step. But Web-based solutions won't reach those who lack computer access, and guidance about eligibility provides only part of the answer for seniors who need help navigating the application process itself."

"While our country debates how to modernize Medicare—reforms that will take years— we need to act now to fix the programs that we already have in place."

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