

Review & Commentary on Health Policy Issues from a Rural Perspective - November 1st, 1998

HMOs—Evolution Or Extinction?

From “Evolution Or Extinction? Experts Say HMOs Must Reinvent Themselves If They Are To Survive” by Chris Rauber, *Modern Healthcare*, 10/19/98:

Bleeding Edge. The Business of Health Care in the New Century, a new book by medical economist J.D. Kleinke, argues that managed care in its current form is unsustainable and will cease to exist within a few years. ‘Profitability that gave rise to the big, national, for-profit managed-care companies was a one-time event, a temporary phenomenon designed to shake up the entire medical financing and delivery system,’ says Kleinke.”

“Managed care worked as a transitional mechanism,’ Kleinke says. But now providers are learning to work the new system, consumers are becoming more sophisticated, and skeptics are questioning the huge chunk of healthcare premiums being gobbled up by managed-care companies for administrative expenses.”

“The current model simply isn’t working as well as it used to, as evidenced by a growing gap between premiums and medical costs, which over the past 18 months has left many HMOs posting big losses and exiting markets. Pressure from providers for higher rates and from consumers for more freedom and fewer restrictions are undercutting the price and utilization controls that kept healthcare costs in check throughout much of the decade.”

“Managed healthcare, particularly the HMO version, is not a terribly sophisticated industry yet,’ says Peter Boland, a Berkeley, Calif.-based managed-care consultant. The industry hasn’t invested enough in critical information technology and has been ‘largely anti-customer in terms of practices and policies. That’s just plain dumb,’ Boland says.”

“But even with a large number of Americans now covered by some form of managed care--127 million out of the 225 million with health insurance, according to the Henry J. Kaiser Family Foundation—HCFA researchers predicted in a recent study that healthcare costs will double to more than \$2.1 trillion by 2007. That’s in large part because the one-time financial benefits of the conversion to managed care have already occurred.”

“If the managed-care model doesn’t evolve in ways that make it more palatable to consumers and a less tempting target for politicians, managed care as we know it may soon be extinct, the analysts say.”

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“The next year or two will be ‘a major decision point’ for the industry, says Joseph Coyne, chief executive officer of Healthcare Databank, a Sonoma, Calif.-based research firm that tracks the managed-care industry. Unless health plans can improve service at the same pace at which they raise rates, they are likely to face further legislation and litigation that will ‘significantly restrict their autonomy in the marketplace,’ Coyne predicts.”

“Fortunately for HMOs, patient-protection laws have been stymied by Washington’s focus on President Clinton’s scandals. But under the surface, the pressure for further regulatory restrictions on HMOs is still there.”

“Managed-care companies continue to face pressure in the marketplace to offer greater access to physicians and fewer restrictions on consumer choice.”

“But if HMOs open up formerly closed panels of physicians and loosen up financial and utilization controls, they will lose many of the features that allowed them to control costs and to ‘manage’ medical care in the first place, some industry experts say.”

“The best thing going for managed-care companies, some analysts say, is the lack of a credible alternative on the horizon—other than some form of government-run,

single-payer system... Consumer surveys show the public is in favor of overturning the managed-care apple cart-until it discovers the cost of doing so. Recent polling on various 'patient protection' proposals shows that many consumers want to pile restrictions on HMOs until they learn the cost, in terms of premium increases."

"So managed care may not be dead, but it's clearly ailing and in need of a burst of creativity and energy. If the industry doesn't heed its wakeup call, observers such as Kleinke say, providers and employers-likely led by coalitions such as the Midwest Business Group on Health-will take matters into their own hands and move more boldly toward direct contracting."

Gatekeeping—Jury Is Still Out

From a "Findings Brief" by Changes in Health Care Financing & Organization, a national initiative of the Robert Wood Johnson Foundation, 8/98:

"Gatekeeping—a system in which health plan enrollees choose a primary care physician (PCP) as a de-facto services-utilization manager and consultant to make decisions regarding the need for specialty providers and services—is a term that is widely recognized within the context of managed health care. But how well the public understands both the objectives of gatekeeping and its effects on health care delivery is not widely known. David Blumenthal, M.D., chief of the Health Policy Research and Development Unit at Massachusetts General Hospital (MGH), and his colleagues asked how does gatekeeping effect access to, quality of, and satisfaction with health care. Specifically, he examined the outcomes for employees who chose to join a health maintenance organization (HMO) that required the use of a PCP gatekeeper, rather than remaining in a similar plan without a gatekeeper."

"Overall, they found that while gatekeeping did serve

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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to lower costs for the insurance carrier, satisfaction with the gatekeeping plan was lower from the perspective of both doctors and patients. And while HMOs are touted as improving rates of preventive care, the study results show that there was no significant increase in preventive care (measured according to number of Pap tests, mammograms, and other screening devices) for the gatekeeping population. In terms of understanding what makes people who have the option choose either an indemnity or an HMO plan, it was found that overall, higher-income employees were less likely to switch. This implies that for those who can afford an indemnity plan, flexibility and choice are high priorities."

"Gatekeeping is recognized as an important and significant change in the way health plans do business," Blumenthal explains. 'It makes sense from the HMOs' standpoint because they can delegate management to the doctors, who theoretically have closer relationships with patients and can better understand what patients need.' But what the researchers found was that doctors themselves were less satisfied with the gatekeeper arrangement. While the gatekeeping plan effectively improved enrollees' continuity of care, its main achievement was to curb the cost of that care."

Small Businesses Bear Brunt Rate Increases

From "Paying A Premium: Small Business Bears Brunt Of Insurance Rate Increases" by Ron Shinkman in *Modern Healthcare*, 10/5/98:"

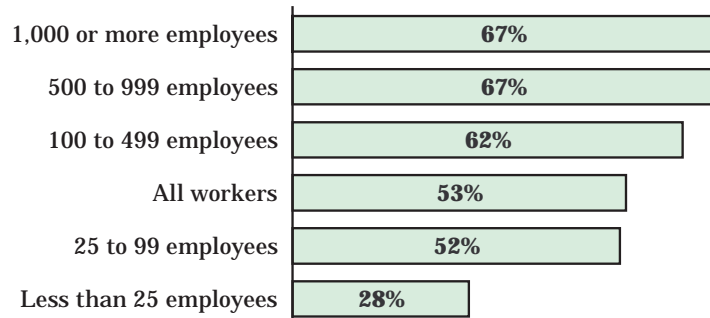
"A recently released study by KPMG Peat Marwick and the journal *Health Affairs* pegged the average increase (of health insurance premiums) at 3.3%. The study credited the continued shift of employees into managed-care plans and provider cost-cutting for holding the line on premium hikes. But there's a dirty little secret behind those numbers. The smaller increases apply mostly to larger companies, those with 500 or more employees. In healthcare bellwether California, for example, smaller businesses have experienced a much larger bite."

"Health Net, a subsidiary of Woodland Hills, Calif.-based Foundation Health Systems, raised premiums 8% to 12% this year for its clients with two to 50 employees. By contrast, larger employers received increases only half the size of their smaller counterparts-just 4% to 6%. Observers agree that smaller businesses are targeted for higher rate increases because of the maxim that bigger is better. 'Small businesses just don't have the purchasing power to deal with a rise in premiums, and they're really getting it from all sides,' says Barry Cockrell, a Jackson, Miss.-based healthcare attorney."

"The guys with over 500 employees have their own pricing history-dictated by them,' says Fritz Mutter,

Employees in Smaller Firms Typical of Rural Communities Less Likely to Have Health Insurance

Percent of Workers Covered by Their Own Employment-Based Health Insurance, by Firm Size in 1997



Data: U.S. Census Bureau, 3/98 Current Population Survey
Graph: RWHC, 10/98

president of Golden Pacific Insurance Services, a Pasadena, Calif.-based insurance brokerage. 'The clients who are under 500 are dictated to.' Adds Pat Carrigan, Golden Pacific's benefits manager: 'I think health plans have held the line as long as they could. We used to see renewals come in flat, even reductions in some instances. Now they're at 10% or more.'

"Health plans apparently are willing to part with a few 30- or 40-employee clients that bristle at a steep rate increase. After all, it takes a couple of dozen of such losses to match the devastation of losing a single client with 1,000 employees. It's also more expensive to administer small-group clients, says Michael Close, Health Net's senior vice president for sales and marketing. "You're processing a lot more billing statements and dealing with a lot more paper," he says, explaining that smaller firms often don't take advantage of electronic claims processing. 'Brokers also take a larger commission for small-group business.'

"Unfortunately, there's not much small businesses can do. Some have the option of trimming benefits and raising out-of-pocket costs, but Health Net's Close noted that benefits packages for small firms have historically been less generous than those for larger employers. And employees at smaller firms are already paying a tidy sum for their coverage. Another study conducted last year by KPMG and *Health Affairs* noted that employees at smaller firms shoulder at least 35% or more of the cost of their own coverage, double what they paid a decade ago, and more than 40% higher than out-of-pocket costs for employees at large firms."

"Healthcare attorney Cockrell predicts a rise in healthcare purchasing coalitions for smaller businesses. But their initial results have not been heartening. The Health Insurance Plan of California, a purchasing pool formed for small employers in 1993 that

covers a total of 130,000 people, recently received rate increases as high as 14%."

"One option that has long been popular for small businesses is switching to a lower-cost health plan. But few believe that practice can continue much longer, given that health plans are under pressure to shore up their bottom lines. 'It's not that hard to change healthcare companies,' Golden Pacific's Mutter says. 'But there really isn't one around these days that's any cheaper.'"

Americans Without Insurance Up Again

From a 9/28/98 Census Bureau Report at www.census.gov/hhes/www/hlthin97.html:

"An estimated 43.4 million people in the United States had no health insurance coverage in 1997, an increase of 1.7 million from the previous year, according to a report released today by the Commerce Department's Census Bureau." The report can be read at:

"About one-half, or 49.2 percent (2.6 million), of poor full-time workers were uninsured in 1997, down from 52.2 percent in 1996. 'Groups most likely to be without health insurance coverage include young adults between the ages of 18 to 24, persons of Hispanic origin, those with lower levels of education, part-time workers and persons who are foreign born,' said Robert Bennefield, the report's author."

"The share of the population without health insurance increased from 15.6 percent in 1996 to 16.1 percent in 1997. Health care coverage of children remained unchanged in 1997; 15 percent of all children were uninsured."

Rurals Shouldn't Sell Selves Cheaply

From "Rural Referrals Represent Significant Revenue For Managed Care Organizations," by Robert J. Parsons, Ph.D., and Kim A. Bateman, M.D., *Healthcare Financial Management*, 9/98:

"A study was conducted to evaluate the potential economic effect of referrals on managed care organizations by rural physicians to providers outside a rural county. Patient referral records and associated financial data were gathered for a three-month period. Referrals by this group of rural primary care physicians to specialists outside their rural county resulted in an average of approximately \$1,100 of collected revenues per episode of care and in an average of more than \$2,600 of expected payments per hospital inpatient stay."

“Rural populations, which normally are more costly and difficult to service than the urban and suburban populations most attractive to managed care organizations, historically have received little direct attention from managed care organizations. When a resident of a rural community is referred to a specialist or clinic outside that community or is admitted to an urban, tertiary care hospital, however, the revenue generated from the referral can have a positive economic effect throughout the managed care community, including managed care organizations.”

“For an HMO to be successful, it must gain sufficient membership in a given locale and have access to an adequate number of primary care physicians. Yet rural areas typically have small, sparse populations and low physician-to-patient ratios. Providing health care to these populations has resulted so far in a low penetration rate of managed care systems in rural communities.”

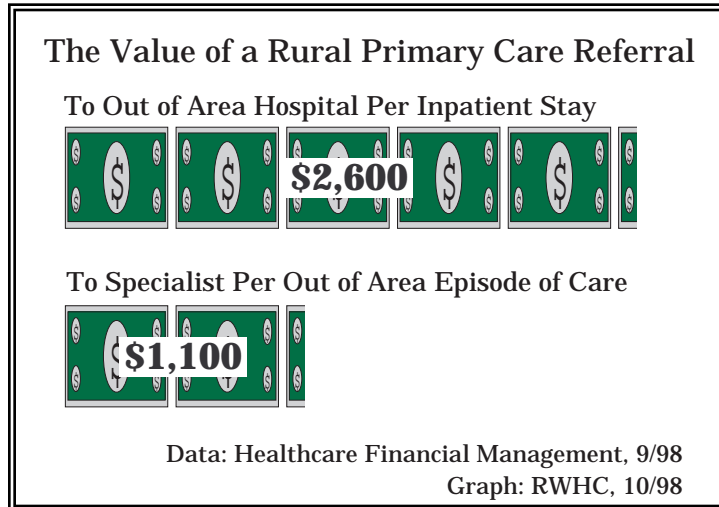
“Rural referrals, however, are of substantial value for urban-based healthcare systems, and the potential for rural patients to access managed care will have a positive influence on their access to health care generally. Managed care providers will need to be sensitive to the aging rural population and the relative higher utilization of healthcare services by the elderly.”

“As this study has demonstrated, rural populations do provide a substantial referral base that helps to support tertiary care hospitals, outpatient services, and specialty physicians, thereby generating revenue that can financially enhance a managed care delivery system. Thus, healthcare organizations that are able to expand their referral bases into rural areas could benefit from providing service to these communities.”

Non-Profit Rural Hospitals Good Investment

From “Value and Risk in the Health Care Sector” in the *National Health Care Group Newsletter* of the A.G. Edwards & Sons, Inc., Investment Banking, 9/98:

“The not-for-profit health care sector has received attention recently in the wake of numerous downgrades and the bankruptcy filing of the Allegheny Health, education and Research Foundation. These events have heightened the focus on the inherent risks of the healthcare sector.”



“In addition to the risks brought on by increased competition and pricing pressure, structural risks contribute to the uncertainty of health care credits. As continued mergers infiltrate the health care sector, new considerations arise. While health care mergers offer many positive credit factors—the ability to reduce costs, increased efficiency, economies of scale and pooled credit strength—mergers can have negative effects on a health system. Mergers can lead to increased debt, integration risk and strategy risk.”

“So where can health care yields be found while avoiding some of the risks? Potential opportunities lie with smaller hospitals located in small towns and in the long-term care sector; smaller facilities located in small towns can offer attractive yields. These smaller hospitals exist without the competitive pressures placed on hospitals in

large metropolitan areas. Small hospitals do have inherent risks as well, such as vulnerability to the loss of a top admitting physician. However, some smaller hospitals possess the financial strength of an A-rated or better credit, but are precluded from such a rating based on their smaller size. Such facilities can, however, receive a BBB or BBB+ rating designation, offering higher yields in conjunction with stronger credit.”

This Year’s Attack On Rural Funding

From “Rural Areas Could Lose Funding Under New Definition” by Jonathan Gardner in *Modern Healthcare*, 10/12/98:”

“Rural healthcare providers fear that proposed changes in the federal government’s definition of medically underserved areas could result in a shift of money and health professionals to urban hospitals. HHS recently proposed changing the criteria by which the Health Resources and Services Administration designates geographic regions as ‘health professional shortage areas’ and ‘medically underserved populations.’”

“Some 2,668 of the 3,141 counties in the U.S. have one or both of the designations for all or a portion of their jurisdictions. Such ‘practitioner shortage’ or ‘medically underserved’ areas are determined by the number of primary-care physicians, poverty and infant mortality. Under the proposed regulation, the number of qualifying counties would fall to 2,350, according to HHS.”

“Hundreds of millions of dollars a year in grants, scholarships and incentive payments are at stake in the change, although no specific figures were available. Whatever the number, the designations are crucial to many providers’ bottom lines in underserved areas. Gaining a designation can make providers eligible for higher Medicare payments and give physicians and other health professionals incentives to practice in those regions.”

“The changes would give urban areas a leg up on getting the dwindling number of designations as medically underserved, rural providers fear. For instance, they said, low-population areas with mostly white residents and very few poor people might not qualify, even though they don’t have enough physicians under current criteria.”

“Clearly, if you look at the criteria, it’s very easy to determine that’s how it’s going,” said Darin Johnson, government affairs director with the National Rural Health Association.”

“The designations are worth a lot to rural providers. Clinics in medically underserved areas can qualify for reimbursement from Medicare and Medicaid on a “reasonable cost” basis, rather than on a fee schedule. Physicians in practitioner shortage areas receive a 10% bonus on their Medicare fees.”

“Health professionals receiving scholarships under the National Health Service Corps are assigned to shortage areas, a practice that aids communities in obtaining physicians and other practitioners. In fiscal 1997, the federal government spent almost \$80 million on the Service Corps program.”

Why Is Wisconsin Last In Federal Spending?

From an opinion letter by Tim Size in *the Wisconsin State Journal*, 10/9/98:

A recent State Journal column by Tom Still suggested that Wisconsin’s Congressional Delegation could be asked why we are last in total federal spending.

A part of the answer is that Medicare spending per enrollee is eighth from the bottom and 25% below the national average. (*House Ways and Means 1997 Green Book*). If Wisconsin’s average payment had been at the national rate, the state would have received almost another billion dollars. This would be an amount coming into Wisconsin equivalent to financing the care for all uninsured individuals with a few \$100 million left over.

Part of the lower Medicare spending in Wisconsin may be due to differences in the average need for health care, but major explanations that should cause a right-

ful challenge of the status quo include inequitable federal payment policies, unjustified regional practice patterns and differences in access to care.

Both a cause and a result of these payment variations is the variation in the availability of basic Medicare HMO benefits. From another perspective, the continuation of these extreme payment differentials reflects maybe another state deficit in Wisconsin, political influence.

Making a Child’s Life on Farm Safer

From the National Children’s Center for Rural Health and Safety (NCCRAHS) in Marshfield, Wisconsin:

“The North American Guidelines for Children’s Agricultural Tasks will help parents and others assign age-appropriate tasks for children ages 7-16 who live and work on farms and ranches across North America. Directing the guidelines are an understanding of childhood growth and development, agricultural practices, principles of childhood injury, and agricultural and occupational safety. Voluntary use of the guidelines can help parents and others make informed decisions about appropriate tasks for youth.”

“A project team made up of individuals from the United States, Canada, and Mexico is using a consensus-development process to generate guideline content. The team includes farmers and ranchers, agricultural safety specialists, and child-development specialists.”

“Quick reference materials for use by parents will flow from the comprehensive report of project findings. Corporate sponsors and collaborating agencies will aid in the preparation, promotion, and dissemination of guidelines to target audiences. Guidelines will be available beginning in April 1999.” More information can be obtained from NCCRAHS at 888-924-7233 or at <www.marshmed.org/nfmc/children>. Other related sites include:

American Academy of Pediatrics--<www.aap.org>.

Center for Disease and Prevention, National Center for Injury Prevention and Control--<www.cdc.gov>.

Farm Safety 4 Just Kids--<www.fs4jk.org>.

Chiropractors--The “Invisible” Rural Providers

From “What Role for Chiropractic in Health Care?,” an Editorial by Paul G. Shekelle, M.D., Ph.D. in *The New England Journal of Medicine*, 10/8/98:

“On September 18, 1895, Daniel David Palmer manipulated the spine of Harvey Lilliard, allegedly restoring Mr. Lilliard’s sense of hearing and founding the practice of chiropractic. From this beginning, despite decades of persecution from government and organized medicine, chiropractors have become the third largest group of health professionals in the United States (after physicians and dentists) who have primary contact with patients. Chiropractors are licensed to practice in all 50 states, Medicare covers chiropractic care for radiographically proved subluxation of the vertebral spine, 45 states have state-mandated benefits for chiropractic, and an increasing number of insurance plans and HMOs are offering chiropractic benefits.”

“In the last decade of the 20th century, chiropractic has begun to shed its status as a marginal or deviant approach to care and is becoming more mainstream. At this juncture, it seems appropriate to ask what the role of chiropractic should be in health care. There is a debate, both within the chiropractic profession and outside of it, about whether chiropractic should be considered a nonsurgical musculoskeletal specialty or a broadly based alternative to medicine.”

“Chiropractic differs from traditional medicine in that it eschews the use of pharmaceutical agents and surgery and instead is based on the body’s ability to heal itself. Central to improving the body’s ability to heal itself, chiropractors assert, is the removal, or correction, of malalignments of the spine (called subluxations) through the use of spinal manipulation (called spinal adjustments). Although chiropractic treatment frequently includes advice about exercise, nutritional supplements, and lifestyle counseling, spinal manipulation is the treatment that is used most often, and it is also the therapeutic method most closely identified with the practice of chiropractic in the United States.”

“What does the scientific literature tell us about the efficacy of spinal manipulation? That spinal manipulation is a somewhat effective symptomatic therapy for some patients with acute low back pain is, I believe, no longer in dispute. The study by Cherkin and colleagues in this issue of the Journal again confirms this finding. Cherkin et al. found that patients with low back pain who were randomly assigned to chiropractic manipulation had a small, marginally significant improvement in symptoms at four weeks as compared with patients who received no therapy other than a booklet.”

“What is in dispute is the efficacy of spinal manipulation in relation to other therapies. Previous studies have compared spinal manipulation with a variety of other therapies, including back exercises, bed rest, and nonsteroidal antiinflammatory drugs. Some of these therapies, such as bed rest, are actually worse than no therapy. Over the past 10 years, the importance of activity in patients with back pain has been increasingly recognized; therefore, Cherkin and colleagues compared chiropractic spinal manipulation with another popular form of treatment, the McKenzie method of physical

therapy. In this approach, patients are taught exercises that will centralize their symptoms and taught to avoid movements that will peripheralize them. Cherkin et al. found no appreciable difference in outcomes between the two approaches.”

The appropriateness of spinal manipulation for non-musculoskeletal conditions is the most divisive issue among medical physicians and chiropractors. Physicians generally accept the role of chiropractic in treating selected musculoskeletal problems but adamantly oppose its use for treating a diverse array of disorders, such as hypertension, asthma, and otitis media, despite numerous case reports from chiropractors of improvement in these conditions with spinal manipulation. Hindering any rational discussion has been the paucity of data from randomized, controlled trials.

“What is the role of chiropractic in health care? In 1979 Dr. Arnold Relman wrote an editorial for the Journal entitled “Chiropractic: Recognized but Unproved.” Nearly 20 years later there appears to be little evidence to support the value of spinal manipulation for nonmusculoskeletal conditions. For this reason, I think it is currently inappropriate to consider chiropractic as a broad-based alternative to traditional medical care. However, for some musculoskeletal conditions, chiropractic care does provide some benefit to some patients. The challenge for chiropractors is to demonstrate that they can achieve this benefit at a cost that patients or health insurers are willing to bear.”

Suicide Is Male Illness & Can Be Treated

From “Killer Instinct” by Donovan Webster in *Men’s Health*, 10/98:

“Parent who kill themselves. Offspring who chose the same path. The roads of life are strewn with these casualties, and a disproportionate number are men. In recent years, science had pointed to a genetic link for other maladies, such as depression and alcoholism. Might some people be wired for suicide?”

“If so, then men must beware: According to the National Institute of Mental Health, suicide afflicts more than four times as many men as women every year, claiming upward of 24,000 men’s lives. And suicide is an option that, for men, climbs only steeply with age. By age 25, men are six times as liable to take their own lives as women are. By age 85, they’re 13 times more likely to kill themselves.”

“We can probably chalk up some of these grim facts to the strange, bottled-up emotional life of the American male. In dozens of requests to suicide survivors and family members, only four people who’ve endured a suicide in the family would speak for attribution—an indication of how off-limits the subject remains. Yet the

men who are afraid to talk about a family history of suicide are the men most at risk.”

“If someone in your family had attempted or committed suicide, you may have a higher-than-normal risk of attempting it yourself. Although not everyone develops acute problems, there are steps you can take to keep suicidal thoughts from catching up with you:

- **Know your prescriptions, know yourself.** Some drugs, especially antidepressants such as Paxil and Zoloft or antipsychotics like Risperdal, can increase suicide risk. Before you accept a prescription for these drugs, question your doctor about how you’ll be monitored.
- **But don’t play doctor.** ‘The most common mistake depressed or suicidal people make is to stop taking their antidepressant medication,’ says John Mann, M.D., a psychiatrist and neurologist at the New York Psychiatric Institute. ‘So if you’ve been given a prescription, use it. Or, if you feel you want to stop using it, check with your doctor before stopping.’
- **Stay off the bottle.** You already know that drinking can intensify feelings of depression that may lead to suicide. But a recent study suggests that a specific gene may influence both suicide and alcoholism. Researchers at the National Institute of Health found that subjects with variations in a specific gene (called TPH) were significantly more likely to be alcoholics, to have problems controlling their impulses, and to have a history of suicide attempts.
- **Stay involved in the world.** ‘Isolation is a factor in many suicides,’ says Yeates Conwell, M.D., a psychiatrist at the University of Rochester Medical Center. ‘You need people to lean on in times of stress. Try to develop a network of people who you can really talk to, and who’ll point out to you when you’re in some sort of emotional trouble.’
- **Keep guns out of the house.** According to the National Institute of Mental Health, 61 percent of all suicides come from the end of a gun barrel, making firearms by far the most common tool in suicides.
- **Know the additional risk factors.** It’s a recognized fact that epileptics have a 20-to-30-times-greater chance of committing suicide than the general population. People who have had strokes or frontal head injuries, or who have lost consciousness, also have higher rates of clinical depression and suicide than the population at large.
- **Check your shoes.** Most people miss the first symptoms of depression—mainly, the tendency to let things slide. If your place is suddenly a mess, you haven’t been to the gym in weeks, and your shoes look scuffed and neglected, you might be entering a depressive episode.

- **Remember that you don’t have to feel this way.** ‘Suicide is a very complex behavior, but it’s usually set off by a particular stressor,’ says Dr. Mann. ‘If you remove the stressor—put the depressed person on Prozac, for example—his suicidal tendencies often disappear,’ Dr. Mann says. ‘Our patient files are full of people who, after you treat the underlying disorder, ask themselves: ‘Commit suicide? What was I thinking?’”

WI AHEC System’s Grass Roots Incorporate

Across the country, Area Health Education Centers (AHECs) work to build community academic partnerships to enhance the training and distribution of providers in order to improve access for underserved populations. In Wisconsin, the governance and administration of both federal and state AHEC dollars has been embedded in the state’s two medical schools. After a seven year gestation, the statewide advisory board has incorporated into WI AHEC System Inc. and will be the body that oversees both the acquisition and allocation of program dollars to the four AHEC regional centers and their academic partners.

Collaboration Can Be Pain In Back

Through a federal grant secured by the Wisconsin Rural Zones of Collaboration, RWHC is managing a data collection project for low back pain in hospital based PT departments. This is a collaborative effort initiated by the RWHC PT Roundtable and expanded to include interested health plans, the state medical society and an employers alliance.

Several meetings occurred between the above organizations to determine what data is needed, what data might possibly be exchanged and how this could be used to improve overall treatment for low back pain patients. Each organization has an active focus on low back pain patients through individual projects. The purpose of the collaborative effort is to obtain data that could be useful to all participants for improving care and to possibly be used as a baseline for implementing changes that are expected to improve the quality and cost of the care provided.

This project includes data collection at the initiation of PT services and again at discharge. At each time point, two forms for data collection are completed; one by the PT and one by the patient. By linking the data, it should be possible to generate a multivariate statistical model describing the relationship between factors at start of P.T. care (e.g., severity of problem, comorbidity, prior treatment, motivation, etc.) and the outcomes of P.T. care (e.g., decrease in pain, improvement in

function, patient satisfaction with back condition). Once developed, such a model would make it possible to predict a favorable or unfavorable P.T. outcome. Having identified those with an unfavorable P.T. outcome, it should be possible to improve the quality of care (i.e., the processes of care) by adapting the clinical guidelines. As data accrues, benchmarking and trending activities should also be possible.

The forms being utilized were developed by the RWHC PT Roundtable under the guidance of Bill McGill who provides data analysis for RWHC. Health plans also reviewed the draft tool. Currently a pilot of the study tool is occurring to determine if any changes need to be made before the full study is implemented. The pilot is being done by P.T. departments in Friendship, Columbus, Richland Center, and Sauk Prairie Memorial Hospital, Black River, Reedsburg and Viroqua.

The full study is scheduled to begin mid-November. The study is being implemented through the P.T. Roundtable consisting of participation of the following RWHC hospitals: Black River Falls, Columbus, Darlington, Friendship, Hillsboro, Lancaster, Mauston, Portage, Sauk Prairie, Reedsburg, Richland Center, and Viroqua. The length of the study will be determined by the volume of cases. Once sufficient pilot data have been obtained, a meeting will be scheduled with interested health plans, the employers alliance and the state medical society to review pilot results and discuss next collaborative steps.

\$1,000 for Best Rural Health Essay

The Monato Essay Prize, established in 1993, is open to all students of the University of Wisconsin-Madison, who are associated with the Center for Health Sciences. The competition was established in honor of the memory of Hermes Monato, Jr., a 1990 graduate, and to highlight the University's need to understand the importance of rural health.

The winning writer will receive a check for \$1,000 paid from a fund established at the University by RWHC, family and friends. The deadline for submission of essays is April 15th; it need not have been written specifically for this prize.

There are no rigid requirements for the length, format, etc. To date, winning papers have ranged from first person essays to formal "journal ready" articles. Please note that essays already written for a class or other purposes during the previous twelve months are also eligible for this competition. For an application form or further information, contact RWHC at <office@rwhc.com> or 1-608-643-2343 or 724 Water Street, Sauk City, Wisconsin 53583. More information is also available at: <www.rwhc.com>.

Tip for Graying Computer Users

Many of us mature keyboard ticklers also wear reading glasses, which are great for books and magazines but just never feel quite right with the computer screen. One solution—over-the-counter reading glasses with a weak lens (1.00 or 1.25) have a focal length closer to the further distance of the computer screen.

This Newsletter Now Available Via Email

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The benefits of this option are that you will receive the newsletter earlier than through the mail, see graphs and photos in their original color, be able to cut and paste newsletter items into your own documents and further your experience with paperless communication. RWHC benefits by you seeing the newsletter in a more attractive format and over time we will save money on postage and handling.

