

Review & Commentary on Health Policy Issues from a Rural Perspective - September 1<sup>st</sup>, 1999

**A Strong Argument for Rural Independence**

From a presentation by Dan Manders, President and CEO of Mile Bluff Medical Center, Mauston, WI, to the Wisconsin Hospital & Health Association 1999 Rural Health Conference:

*Where We Are*

"Location, location, location! We have it. Some may say we are blessed with it, while others may say we are cursed. Many would say that we are in the middle of nowhere but I prefer to think we are in the middle of everywhere. We are on Interstate Highways I90 and I94, equidistant to Madison, La Crosse, and Marshfield. It's 70 to 75 miles to each and all of them have one or more major organizations that are very respected and very much looking to enhance their business. This provides a lot of opportunities for competition or a lot of opportunity for partnering."

"We are the only hospital in Juneau County which has a population of about 24,000 people. Our county for years has suffered high unemployment and has been

considered economically depressed. We had Health Professional Shortage Area designation until a couple years ago."

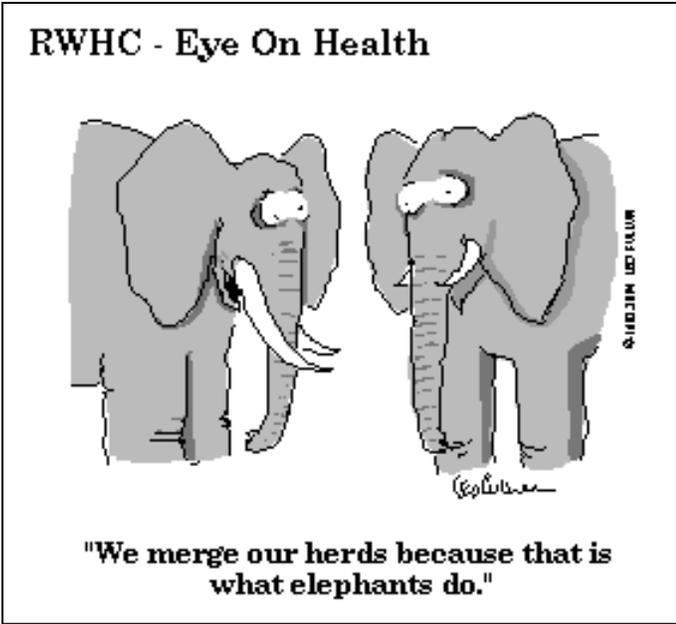
"We have the Petenwell and Castle Rock flowages in our area which are the 2nd and 3rd or 2nd and 4th largest lakes in Wisconsin. (It depends on which tourist brochure you read.) This adds a significant amount of our admissions and 15% of all outpatient volumes are tourists related at our last count."

"We also cover between 30 and 40 miles of Interstate 90 and Interstate 94. This leads to significant amounts of trauma being brought to our facility."

*What We Are*

"Mile Bluff Medical Center is made up of a number of components. Most are under the non-profit corporation, but two are owned and operated by a for-profit physician partnership."

- "We have a 37 bed acute care hospital (Hess Memorial Hospital) in Mauston. We have about 2300 admissions per year and see about 60,000 outpatients.
- We have a 60 bed skilled nursing home (Fair View Home) in Mauston. It runs at 98% occupancy.
- There is a 40,000 square foot clinic with 11 family practice doctors, 2 surgeons, 1 podiatrist, 4 PA's, 2 NP's, and 50 visiting specialists attached to the hospital and owned by the physicians.
- The physicians also lease a building in New Lisbon which is staffed by 1 family practice doctor and 2 PA's.
- The hospital operates 2 clinics, one in Elroy and one in Necedah. These are staffed by 1 family practice doctor and 2 PA's. All of the clinics were certified as rural health clinics before we lost our HSPA.
- We have a 34 unit retirement center on the main campus (Terrace Heights). We have 3 units open at this time.



- We have a home health service (Hess Home Health) with offices in Hess Memorial Hospital and Tomah Memorial Hospital. As a reciprocal agreement, Tomah Memorial has an office of their hospice unit in our hospital.
- We have a 9 station dialysis unit (hospital owned and operated) in space we lease from our physicians in their clinic in Mauston.”

*Why We Have Accomplished What We Have*

“Independence and local control is, has been, and will continue to be, a major factor in our success:

- With local control, we sit down with our local board members who are local residents, our medical staff, and our administration and make a long range plan that we feel meets our needs in Juneau County. No one can override for budget, competition or any other reason. It is ours, made by us. A key here is relationships. We work on relationships continuously, but we find the 3 most important are board, medical staff, and administration. We must all get along and cooperate. We do. Of course we disagree at times, but we always try to keep that ‘Vision Thing’ in front of our eyes. We also like to say that ‘You have to sit on your elbows.’ In other words, don’t fight the ‘little battles’ just to win. Analyze disputes by, how will the whole benefit the most. Always remember ‘No Margin, No Mission.’
- Another key as to why we succeed and why we believe in the independent model is our ability to react quickly. When an opportunity arises, there are not layers of administration from which to obtain approval and there is only one board to decide things.
- Flexibility obtained through local control has allowed us to partner with whoever provides the best fit for a program or service. We currently partner with UW Hospital, UWMF, Meriter Hospital, Dean Physicians, Marshfield Mayo Clinic, Tomah Memorial Hospital, Adams County Memorial Hospital, Reedsburg Medical Center, RWHC, WHA and Juneau County (we have a jail program).
- Choice of Specialty Services from Tertiary Care Facilities--on any one day in our clinic, we may have doctors from a half-dozen medical systems.
- Recruitment--some of our doctors and other practitioners like to be where they can interact directly with the decision makers. Also because of our size we can offer various arrangements to new recruits from independent shared practice, to part independent and part hospital employed to total hospital employed. Yet even our hospital employed doctors are eligible to buy into the clinic building partnership and no matter what the arrangement, we are one medical staff (all 4 clinics) with one call system, joint scheduling at all clinics, shared general ex-

penses, and shared decision making. We also keep one active medical staff member on our board of directors.

- Market knowledge is very important and because all of our doctors, board members, and administrators live and work in our market, you get a feel for things. We all grocery shop locally, buy cars locally, go to church locally, etc. We often are approached at any of these functions and are told what’s good about what we are doing, as well as things that could be done better. You live in a small town, you hear it whether you want to or not. Listen to your community.
- Independence helps to keep incentives more closely aligned. The more quality services we provide locally the better. Period. Is that the case when you may take business away from your affiliated partner?
- Cost of services can often be done at a lower rate if you avoid the inefficiency that comes with layers of bureaucracy, especially if you run into ‘the system does it this way for the good of the system.’ The only system you have to worry about as an independent is your own.”

*Negatives of Independence*

“Some of the issues that you must overcome as an independent are:

- Capital needs. This is huge to many rural facilities. You noticed we have had to have fund drives in the past, as well as use government programs and financing. These are not fun, but they were necessary. For our last major borrowing (\$12 million), we worked through our local bank, who set us up with Bank One in Columbus, Ohio, who set us up with 3

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.

*Eye On Health* Editor: Tim Size, RWHC  
 880 Independence Lane, PO Box 490  
 Sauk City, WI 53583  
 (T) 608-643-2343 (F) 608-643-4936  
 Email: [timsiz@rwhc.com](mailto:timsiz@rwhc.com)  
 Home page: [www.rwhc.com](http://www.rwhc.com)

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mutual funds, who bought all our bonds. It was complicated, but it worked.

- Staff expertise is another area of concern of independents. Finding depth and quality in staff is difficult in rural areas, especially in finance, information management, education, and other specialty areas. We have overcome that in a number of methods. The RWHC has great programs in financial consulting, credentialing, JCAHO approved Quality Data Systems, etc. We have also utilized Gundersen Lutheran education department to tailor make management seminars, etc. for our staff. They come to Mauston and teach these. We also use the tertiary care hospitals to train our people. We often have people at UW or Marshfield or La Crosse spending a week or more just observing learning.
- Recruitment is any area where some doctors like the security of a system. We don't recruit these folks.
- Loss of economics of scale is something we have had to deal with in rural health from day one. All you can do is use your best judgment as to when a service can be offered at the quality and price your community demands.
- Rural conservative mind set. If your board, medical staff, and administration will not take risks, you better partner with someone who will help you do so. 'If you're standing still, you're going backward.'

*Postscript: A delegation of twenty rural Chinese provincial government health administrators will be visiting Mile Bluff Medical Center this month in an effort to better understand the American healthcare system.*

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### “Could We Just Sort Of Legislate?”

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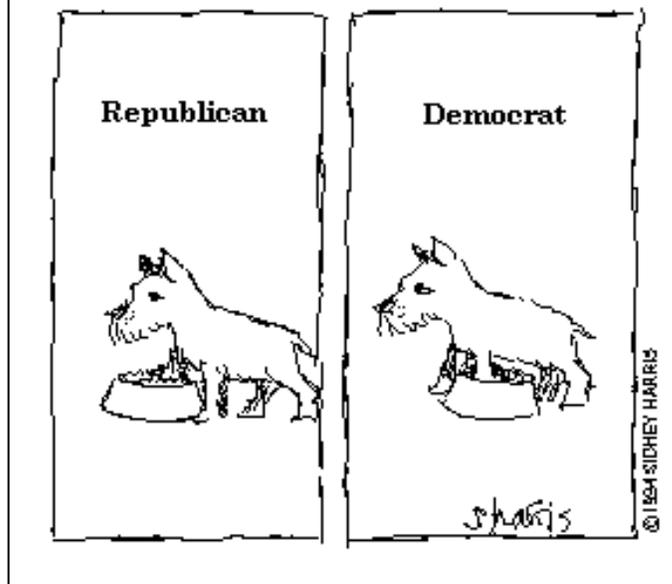
From “Compromise Takes a Holiday” by Alison Mitchell in *The New York Times*, 8/8/99:

“Congress went home for the August recess late last week with little to show for itself beyond an arsenal of political sound bites stockpiled to serve as campaign themes for a high-stakes election that is still more than a year away.”

“The achievements the 106<sup>th</sup> Congress so are scant--mainly giving states more flexibility in using Federal education funds and another requiring deployment of a national missile defense system. And across an array of fronts, Republicans and Democrats seem more interested in campaigning than legislating.”

“Legislation to regulate the managed care industry passed the Senate but has yet to make it to the House floor because of Republican fears that they could lose control and give the Democrats a victory on the issue.

### RWHC - Eye On Health



Despite the school shootings in Littleton, Colo., another school year will open without any new gun control measures. And though President Clinton has proposed restructuring Medicare and adding a new prescription drug benefit, the issue has simply drifted into the fall.”

“ ‘They keep saying, ‘the election,’ said Senator Olympia Snowe, Republican of Maine. ‘And I say that’s a year and a half from now. In the meantime could we just sort of legislate?’ ”

“Still, it has been said that in a democracy the people get the government they deserve. The voters put in place a recipe for gridlock when they elected a Democratic President, a Republican Senate and a House nominally in Republican control but actually divided nearly in two.”

“Sorting out what the nation’s fiscal priorities should be across a decade that is expected to bring in a \$3 billion surplus is a profound political decision with far-reaching consequences. So it’s no wonder that the two parties want to fight out their differences in the 2000 campaign in hopes that next year’s election--unlike the last Presidential year of 1996--will help settle some of the arguments.”

“The reapportionment of 1990 left many Congressional districts safely Republican and others overwhelmingly Democratic, giving most House members little need to search for a center ground. The Democrats who were once willing to vote with Ronald Reagan have become Republicans. Liberal Republicans are almost extinct.”

“Low voter participation in mid-term elections has also pushed Republicans and Democrats, most particularly in the House, to cater to their most devoted core voters and donor base.”

“ ‘Increasingly Congress has become polarized,’ said Marshall Wittmann, a Congressional analyst at the conservative Heritage Foundation. “This has been a long-term development over the last 20-odd years. What you essentially have is a conservative party versus a liberal party.’ The result is that even when the two parties sound alike, their rhetoric masks profound differences. Democrats say they support a tax cut too -- just a smaller one than the Republicans. But most Democrats put their passions into new programs like one to help with school construction or a new Medicare prescription drug benefit.”

“And while Senate Republicans came up with a ‘Patients’ Bill of Rights Plus’ to counter the Democrats’ ‘Patients’ Bill of Rights,’ the Republican managed care bill was so much weaker than the Democrats’ version that it almost seemed to highlight the Republicans’ aversion to regulation.”

“It would take a reservoir of trust and good will to find a way around such differences. But the impeachment battle left trust between the parties in short supply. And the razor-thin majority in the House has made matters worse: The parties judge every issue by its likely effect on the 2000 election. So Democrats accuse Republicans of passing a large tax cut to create a campaign issue. Republicans insist that Democrats are blocking bills, like a Republican gun control bill because they want to run against a do-nothing Congress.”

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## The Case for a Patients’ Bill of Rights

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From “Time has come for a patients’ bill of rights,” a guest editorial by US Senator Herb Kohl in *MEDIGRAM* at <[www.wismed.com](http://www.wismed.com)>, the newsletter of the State Medical Society of Wisconsin, 7/28/99:

“For many years, managed care has helped to rein in the rapidly growing costs of health care. That benefits all patients across the nation and helps to keep health care costs in check.”

“However, there is a real difference between making quality health care affordable and cutting corners on patient care. In Wisconsin, we are lucky that most health plans do a good job in keeping costs low and providing quality care. But too often across this nation, HMOs put too many obstacles between doctors and pa-

tients. In the name of saving a few bucks, too many patients must hurdle bureaucratic obstacles to get basic care. Even worse, too many patients are being denied essential treatment based on the bottom line rather than on what is best for them.”

“The Patients’ Bill of Rights ensures that patients come first--not HMO profits or health plan bureaucrats. It makes sure that doctors, in consultation with patients, are the ones who decide which treatments are medically necessary. It gives patients access to information about all available treatments and not just the cheapest. In far too many cases, these decisions are made by an HMO bureaucrat with a calculator instead of the patient and their doctor. The Patients’ Bill of Rights puts these decisions back in human hands where they belong.”

“This legislation also makes sure that health plans are held accountable for the decisions they make. First, all health plans must have an external appeals process in place, so that patients who challenge HMO decisions may take their case to an independent panel of medical experts. And second, if a

health plan’s decision to deny or delay care results in death or injury to the patient, this bill ensures that the health plan can be held accountable for its actions.”

“Most importantly, this bill gives all of these protections to ALL Americans in managed health care plans, not just a few. All 161 million Americans in managed health plans deserve the same protections — no matter what state they live in.”

“There is no reason whatsoever to continue to allow health plans to skimp on quality in the name of saving profits. Patients have been in the waiting room long enough. It is time for the Congress to act and make sure patients receive the health care they need, deserve, and pay for.”

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## Too Much Privacy Hazardous to Your Health

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From “Too Much Privacy Is A Health Hazard” by Thomas Lee, M.D., in *Newsweek*, 8/16/99:

“Consider what happens when a doctor writes you a prescription. If that doctor doesn’t know about every

### Caring for the Country--Support the National Rural Health Association



NRHA is for everyone who cares about standing up for rural health in W.D.C.

Join or make a donation today by contacting NRHA at 816-756-3140 or [www.NRHArural.org](http://www.NRHArural.org)

Or Call Tim Size at RWHC for more information.

other drug you're using, the results can be disastrous. Patients have died because one doctor prescribed Viagra for impotence and another ordered nitroglycerin for angina-- a combination that causes dangerous drops in blood pressure. Most deaths from drug interactions could be prevented by databases that show every prescription for a particular patient. Physicians have to rely on what patients remember, or chose to disclose."

"Even when privacy advocates concede that doctors need unfettered access to patients' records, most favor shielding them from HMO administrators. But a responsible health plan can put clinical information to good use. As part of a 'disease management' program, an HMO may use computer software to determine whether patients with a chronic condition, such as asthma or hypertension, are filling their prescriptions and showing up for appointments. Those who fall behind may get a reminder by mail or phone. These programs can measurably improve people's health, but patients often miss out on them by refusing to authorize access to their records."

"With a little creativity and common sense, we'll find a way to protect privacy while ensuring that doctors have the information they need to take good care of people."

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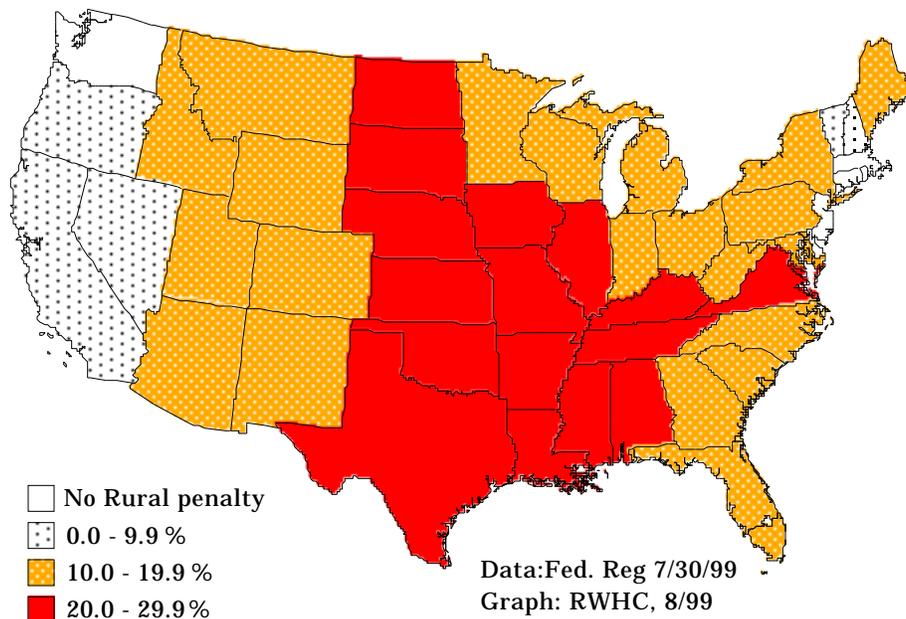
### Medicare--Same Old, Same Old

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Rural hospitals and physicians continue to face fundamental challenges with the Medicare program, now made worse by the Balanced Budget Act. While progress has been made in certain areas, the following excerpt from the RWHC "archives," is still very relevant-- "Medicare's Disproportionate & Inequitable Impact On Rural Health" by Tim Size, 7/95:

- "Medicare is the payment source for less than 20% of the nation's health spending.
- There are 1,870 rural hospitals (36% of all hospitals) with fewer than 100 beds.
- Hospitals with fewer than 100 beds receive only 6% of Medicare Prospective Payment System payments.

### Medicare Wage Penalty Hits Central USA in New Millenium



Percent deducted in rural counties per state from what is paid on average nationally for wages.

- Medicare represents 50% to 70% of the revenue for most small rural hospitals and is the single largest payer for rural clinics."

**"The bottom line: Medicare casts a long shadow over rural health while rural health is largely ignored by Medicare."**

"Rural health has a troubled legacy from the Medicare program. The overwhelming and disproportionate share of patients seen by rural providers are Medicare enrollees while in a contrary manner, rural health represents a very minor portion of Medicare program expenditures. The small portion of Medicare expenditures for rural communities makes it difficult for them to gain the attention needed to solve long-standing rural equity issues. In summary:

The Cooperative understands the long-term funding challenges faced by the Medicare Trust Fund and wants to be part of the solution. We believe that the context for the solution is well stated as follows: 'An overwhelming majority of Americans say the Medicare program must be changed. But a national survey shows that the public remains wary of efforts to dramatically overhaul the financially strapped program and will accept cuts in the growth of Medicare spending - but only to save Medicare and not to balance the federal budget or fund a tax cut.' ('What Americans Think,' *The Washington Post Weekly Edition*, 7/10/95.)"

"It is now critical to finally address specific areas of on-going Medicare rural discrimination:

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## Health Poor for Workers Out of View

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- The lack of a single Medicare payment area in most rural states for physician services, perpetuating the effect of decades old but no longer relevant geographic pricing differences.
- The structure of the Medicare Wage Index (i.e., separate indices for each MSA but with all rural provider wages dumped into one statewide pool) and the failure to aggressively develop a model that more fairly describes the price of labor faced by rural hospitals.
- The failure to occupationally mix adjust the data used to develop the current Medicare Wage Index - a short coming that tends to over pay large hospitals and underpay small hospitals and inhibit the development of an improved Wage Index model.
- The distortion of the rural Medicare Wage Index by the inclusion of non-acute care salaries into the data base (particularly problematic for the many combination hospital/nursing home facilities found in the upper Midwest.)"

**RUPRI (Rural Policy Research Institute) has just released a report entitled: *Implementation of the Provisions of the Balanced Budget Act of 1997: Critical Issues for Rural Health Care Delivery--P99-5*, available as a RUPRI Update at:**

**[www.rupri.org](http://www.rupri.org)/<http://www.rupri.org>**

NAG Adv here

Last month, the National Children's Center for Rural and Agricultural Health and Safety introduced its advisory committee to the life of migrant worker children in Wisconsin--offering a view of this often invisible population <<http://research.marshfieldclinic.org/children/>>.

To support a bit more visibility, the following is from the National Center for Farmworker Health, Inc., <<http://ncfh.org/>>:

### *Profile of a Population With Complex Health Problems*

"The results from this study are significant, shocking, and convincing. The findings are based upon a sample of migrant and seasonal farmworkers living and working in the U.S., yet their demographic patterns, socioeconomic conditions, life-style characteristics, and disease categories reflect agrarian third world conditions rather than those of the most powerful and affluent nation in the world."

"Factors such as poverty, malnutrition, infectious and parasitic diseases, poor education, a young population, and poor housing equate to a highly vulnerable population in need of resources. Clearly, the migrant population is at greater risk and suffers more problems than the general population of the U.S. The results of this research demonstrate the need for more services, care, and treatment. The need for developing a health policy and research agenda for migrant farmworkers in this decade is evident."

"Now, thanks to a partnership between the Migrant Clinicians Network and the National Center for Farmworker Health (formerly known as the National Migrant Resource Program), the first national study of morbidity in the farmworker population gives us solid evidence that their health status is far below that of the general population."

### *Comparison with General Population*

"Migrant farmworkers have different and more complex health problems from those of the general population."

"Migrant farmworkers suffer more frequently from infectious diseases than the general population."

"Farmworkers have more clinic visits for diabetes, medical supervision of infants and children, otitis media, pregnancy, hypertension, and contact dermatitis and eczema."

"The farmworker population has more young people and fewer older people than the general U.S. population."

## Health Status by Age

"Clinic visits for ages 1-4 are mostly for infectious and nutritional health problems. Health problems for ages 5-9 are also primarily infectious, but dental problems also appear for the first time in this group."

"Dental disease is the number one health problem for patients aged 10-14."

"Pregnancy is the most frequently presenting health condition for females aged 15-19; dental disease is number one for males."

"Females age 20-29 visit clinics primarily for pregnancy, diabetes, common cold, and reproductive problems. Males visit primarily for contact dermatitis and eczema, strep throat and scarlet fever, and dental problems."

"In the 30-44 age group, two of the top three problems for both males and females are diabetes and hypertension."

"Nearly half of all clinic visits for men and women in the 45-64 age group are for diabetes, hypertension, or arthropathies."

"Among the elderly, over 60 percent of clinic visits by males and 80 percent by females are for diabetes and hypertension."

### Multiple Health Problems

"Multiple and complex health problems exist among over 40 percent of all farmworkers who visit migrant health clinics."

*This study of migrant health status was completed by G. E. Alan Dever of Mercer University under contract to the National Migrant Resource Program. Funding for the study was provided by the U.S. Department of Health and Human Services. For more information, contact the National Center for Farmworker Health, Inc., at P.O. Box 150009, Austin, TX 78715, (512) 312-2700.*

## Wisconsin Labor Market Information

[www.dwd.state.wi.us/dwelmi](http://www.dwd.state.wi.us/dwelmi)

## Self-Employed BadgerCare Access Improved

From *WI BWI Operations Memo 99-50*:

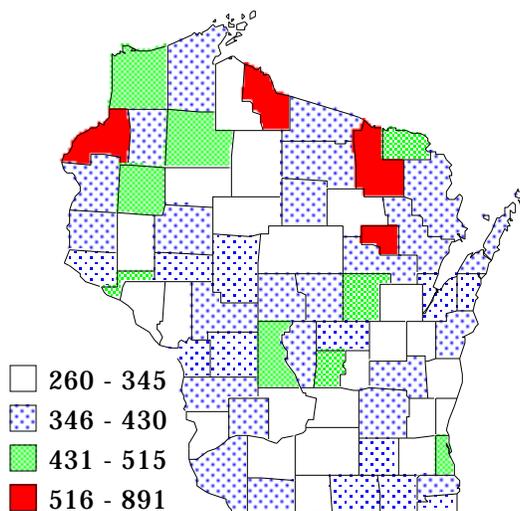
"The farmer (and other owners of self-employed enterprises) who drops his or her health insurance coverage in the month prior to application for BadgerCare does not have to wait three months before BadgerCare eligibility can begin (if dropped for all employees.)"

**Phone Toll Free, 1-800-362-3002, for BadgerCare Enrollment Procedures and Assistance.**

## Want to Live Longer?--Location Matters

**County mortality rates (age adjusted) for those younger than 75 years of age range from a low of 261 per 100,000 in Taylor County to 890 per 100,000 in Menomonee County--3.4 times that of Taylor County.**

### The Ultimate Health Scorecard



**Deaths per 100,000 population**  
1996 Age-Adjusted Mortality for  
Persons Under 75 Years;

Data: WNHPR 8/99  
Graph: RWHC 8/99

From the *Wisconsin County Public Health Check-up* by the Wisconsin Network for Health Policy Research (WNHPR), <[www.medsch.wisc.edu/prevm ed/network](http://www.medsch.wisc.edu/prevm ed/network)>:

"Population health is a concept that includes both the length and the quality of life of individuals as well as the overall condition of all people in the population. Among the determinants of population health are:

- health care services,
- social and economic conditions and services,
- behavior and life-style; environment and genetic endowments."

"In WNHPR's *Public Health Check-up*, they ranked Wisconsin's 72 counties from healthiest to least healthy using three measures--mortality, income and discharges for Alcohol/Drug Abuse."

"For more information regarding population health in Wisconsin, request a brochure from Judy Knutson at (608) 263-6294, or at <[jaknutso@facstaff.wisc.edu](mailto:jaknutso@facstaff.wisc.edu)>."

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## Mega-Web Link List

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The Wisconsin's Women's Health Foundation (Co-chaired by Sue Ann Thompson) has just passed its first year and is beginning to build up speed. Their mission is to:

- "Reach all Wisconsin women with the information, opportunity, and support the need to be healthy;
- Encourage women to become advocates for their own health; and
- Improve the overall quality of life for women and their families."

RWHC has been doing some volunteer work for the Foundation. As part of that assignment, they made available a comprehensive list of over 200 www sites with information and data particularly relevant to women's (and men's) health, prepared by Meridian Resource Corporation. The list is on the RWHC website:

[www.rwhc.com/WWHF.Data.Base.html](http://www.rwhc.com/WWHF.Data.Base.html)

Search engines are great tools but sometimes a good list is also very helpful. With this as an example, we will be hearing more from the Wisconsin Women's Health Foundation. More information about the Wisconsin Women's Health Foundation can be obtained from Kris Andrews, 608-251-1675 or <[kan-drews@chorus.net](mailto:kan-drews@chorus.net)>.

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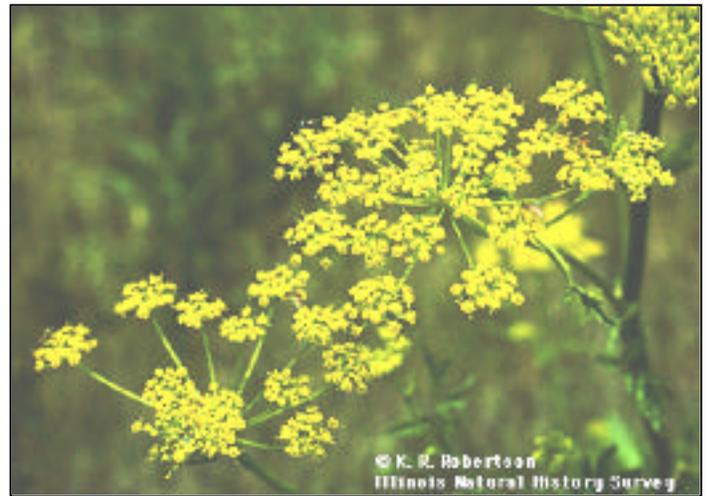
## PHYTOPHOTODERMATITIS

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Most of us know to avoid the shiny three leaf poison ivy but it turns out many folks aren't aware of the much nastier Wild Parsnip. As a son and friend have discovered, this very common Wisconsin plant can spell big trouble when it, your skin, sweat and sunlight come together. From the WI Dept. of Natural Resources:

"Wild parsnip can cause phytophotodermatitis to the skin. If the plant juices come in contact with skin in the presence of sunlight, a rash and/or blistering can occur, as well as skin discoloration that may last several months."

"Wild Parsnip produces flowering plants that produce a single, thick stem that contains hundreds of yellow flowers (in multiple 'umbrella' shapes--looks like a yellow Queen Ann's Lace;) grows to over four feet in height. Wild parsnip rosettes are among the first plants to become green in spring, and its flowers turn a prominent yellow in midsummer. After flowering and going to seed, plants die and turn brown in fall.



Common along roadsides, abandoned fields, unmowed pastures, edges of woods, prairie restorations."

"If you get a parsnip burn, relieving the symptoms comes first. The affected area can be covered with a cool, wet cloth. If blisters are present, try to keep them from rupturing for as long as possible. The skin of a blister is 'nature's bandage,' as one doctor put it, and it keeps the skin below protected, moist and clean while healing occurs. When blisters pop, try to leave the skin's 'bandage' in place. To avoid infection, keep the area clean and apply an antibiotic cream. For serious cases with extensive blistering, consult a physician."

"Avoiding exposure, of course, is the wisest tactic. By learning to recognize the plant in different seasons and in different stages of growth, you can steer clear of it, or protect yourself by wearing gloves, long pants and long-sleeve shirts."

### RWHC - Eye On Health



"K.I.C.--Keep It Confusing--that's our advantage over providers and covered lives."