Rural Wisconsin Health Cooperative

Eye On Health

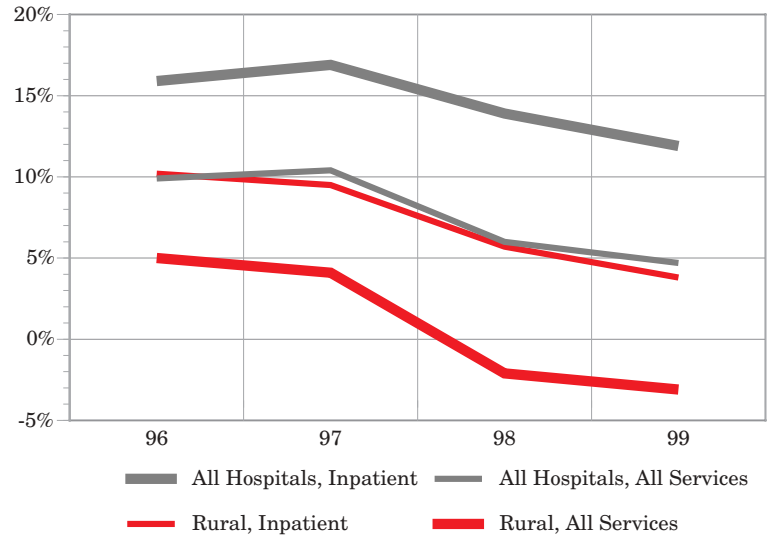
Review & Commentary on Health Policy Issues for a Rural Perspective - May 1st, 2002

Rurals Ask For New Federal Relationship

The following is from the written testimony given by Tim Size on behalf of RWHC at the Department of Health and Human Services (DHHS) Secretary's Advisory Committee on Regulatory Reform meeting in Pittsburgh on April. The complete testimony with all of the specific recommendations is available online at http://www.rwhc.com. The graphics were prepared for a separate event, the Wisconsin Medicare Summit in Madison on April 30.

"We appreciate the opportunity to testify today at the request of Secretary Tommy Thompson. RWHC was founded in 1979 and we began working with the then State Representative from Elroy shortly thereafter — we never doubted that rural health would be a priority for this Secretary."

Aggregated Medicare Margins Drives Most Debate But Rural Hospital Margins Are A Different Reality



Data: MedPAC, 3/02
Graph: RWHC, 3/02

Continue To Build Federal/Rural Collaboration

"Departmental leadership and attitude throughout DHHS is critical; keep up the work to create your 'culture of responsiveness.' For those of us 'in the trenches,' it has appeared easier in the past for too many to play off of embedded stereotypes about the so called 'provincialism' of rural hospital boards and administrators then to look inward at the Department's historic and systemic failure to design and manage an equitable Medicare program. Secretary Thompson, with his symbolic act of renaming HCFA, told us that he was committed to a cultural shift unprecedented in the agency's history. I would encourage people to take him at his word as I know 'failure' on a key priority isn't in his leadership vocabulary."

"It is clear that CMS head Tom Scully is equally committed. We are seeing a real difference as a result of the 'Open Door' and related initiatives. We find the CMS Regional Rural Health Coordinators to be very helpful. The Region V Office has done an exemplary job reaching out to rural providers and responding to individual regulatory questions and problems. Our primary recommendation is that you institutionalize this new culture—the immense scope of DHHS means that each year there are new weeds to be pulled."

"DHHS should continue to proactively involve its Office of Rural Health Policy early within the policy and regulatory process on all issues affecting rural health. Many rural regulatory and payment problems can be avoided by accessing ORHP's rural focused expertise."

"Rural communities need a fundamentally new federal relationship if they are to prevail over an intimidating array of major challenges. This is not to blur government and provider responsibilities but it is to say that collaborative models are an alternative to the failed mythology of micromanaging the providers of American health care."

Continue To Develop An Understanding Of Rural Realities/Context

"It has often been said that rural communities tend to be older, poorer and sicker. There are also key organizational differences. These differences should inform how DHHS works with rural communities and providers; here is but one example:

- Dr. Ira Moscovice at the University of Minnesota states convincingly that differences in context between rural and urban hospitals result in systems of different complexity which in turn result in different types of errors and different demands for managing errors. High volumes and large bureaucracies tend to create one kind of management or regulatory challenge while the low volume, more personal settings create another."

"Consistently Disaggregate Data—DHHS should consistently disaggregate data so that the rural context is explicit. Rural realities are often masked through a failure to collect or present data that adequately describes actual conditions, a reality hidden by averages."

"Do A Rural Impact Analysis Before Proposing Regulation—With any regulatory proposal to change a federal program, the DHHS should include a rural health impact statement that includes an impact analysis on vulnerable rural providers—safety net providers, primary care providers, hospitals, RHCs, FQHCs as well as the impact on local rural communities and economies."

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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Source Of $1 Billion Annual Medicare Shortfall

Medicare CY 1998	Rural WI Enrollees	Urban WI Enrollees	All WI Enrollees
Number Enrollees	286,000	482,000	768,000
Payment Per Enrollee/Year	$3,694	$4,361	$4,108
(Loss) Compared To USA Avg Of $5,299	($1,605)	($938)	($1,191)
WI (Loss) By Not Receiving Avg National Payment	($459 M)	($452 M)	($911 M)

Data: ***Medicare/Medicaid Statistical Supplement, 2000***
Graph: RWHC 4/02

"Invest In Rural Best Practices—DHHS should allocate the necessary funding to the Agency for Healthcare Quality and Research for research and dissemination of best practices relevant to the scale and context of typical rural facilities. Research should reflect the diversity of settings in which patients are seen, not only those most convenient for researchers."

Support The Rural Community Hospital Assistance Act (RCH)

"While I understand the distinction between regulatory reform as the topic of this hearing and congressional initiatives such as RCH, the newly introduced RCH bill to restructure rural hospital Medicare payments needs to be noted. In brief, the proposal would:

- Enhance the Critical Access Hospital (CAH) program, which provides special Medicare reimbursement for certain rural hospitals with 15 or fewer inpatient beds.

- Help other rural hospitals with 50 or fewer inpatient beds by providing adequate Medicare reimbursement and additional funding for technology and infrastructure needs."

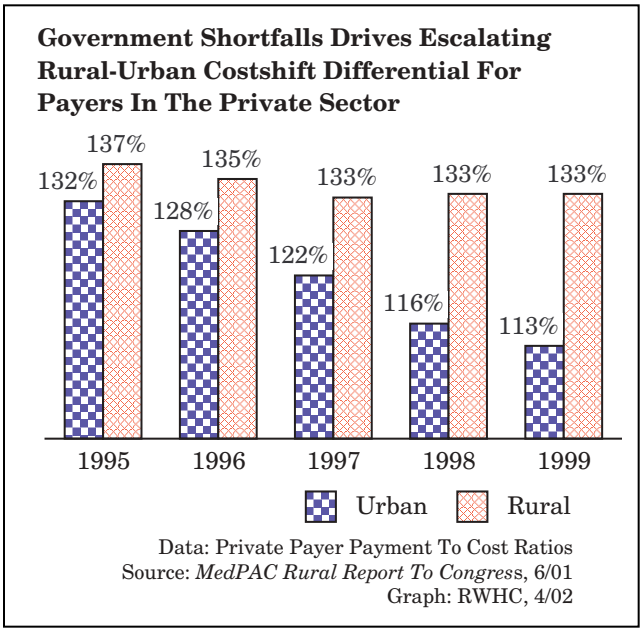
"In 1985, during the second year of Medicare's Prospective Payment System (PPS), the National Health Policy Forum at George Washington University hosted an invitational workshop on "PPS Design: Tackling Major Structural Issues." On behalf of rural hospitals, I requested the development of a model more sensitive to actual labor markets than one where the wage scale takes a nose dive at the urban county line. A senior representative of the Health Care Financing Administration (HCFA), responded with a less then helpful "get used to it, all models have their boundary problems." Weeks later, Carolyne Davis, then head of

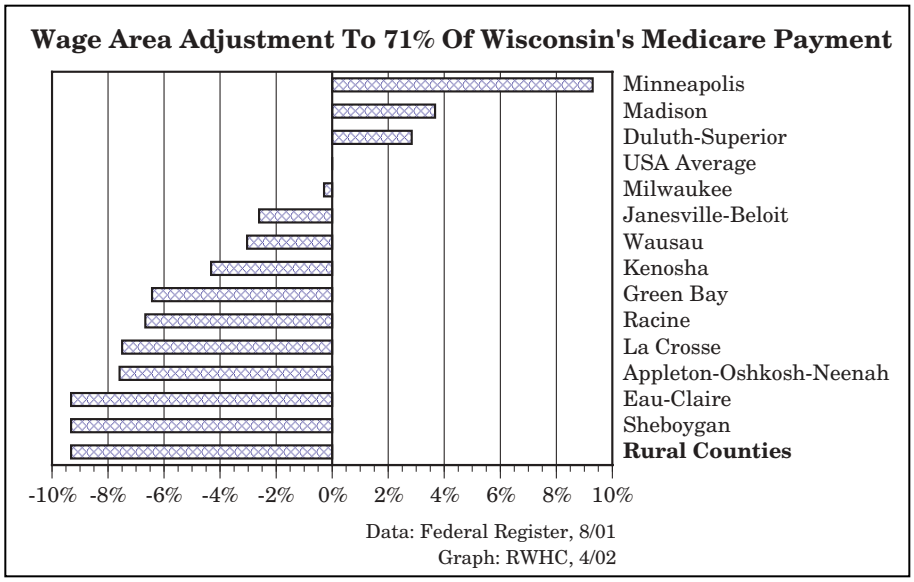
HCFA (now CMS), stated that they would answer questions about rural wages by the end of the year. **We are still waiting for a fair PPS wage policy.**"

"For rural providers, the fundamental inequity in PPS is in part a result of our not having been at the table back in the early 1980s when the foundation for the PPS model was set. Put less kindly, "rural advocates were asleep at the switch." Urban advocates were successful in seeing that their hospitals were compensated for the effects of their local markets through disproportionate share payments and the use of a wage index. Rural hospitals were lumped into statewide markets and were not compensated for the effects of their local markets—markets with low volume and requiring high overhead. Low volume and high fixed costs kill rural hospitals—it is a "condition" that they face, just as some urban hospitals face having a large safety net requirement or relatively higher labor market."

"The ongoing failure of Medicare to address rural market conditions in a manner consistent with its recognition of urban conditions has led to Medicare operating margins disproportionately lower for rural providers, hospitals in particular. It has undermined the credibility of the Program and cast the federal government as an adversary to rural communities as they seek to provide local health care."

Address Longstanding Medicare Rural Biases





"Do Not Water Down The Occupational Mix Adjustment—Federal law (BIPA) now finally requires an implemented occupational mix adjustment to the wage index no later than October 1, 2004. We believe that some of those who will lose under this long awaited technical adjustment are working to delay or water it down by arguing within the Department for 'less onerous' data submission requirements and for as much of the status quo as they can retain."

"Lower Percentage DRG Adjusted By Wage Index—The percentage of the DRG modified by the wage input should be lowered to reflect the actual proportion of goods and services affected by area wages. The input categories included in the labor share are long outdated, having been selected in 1983. The current national average labor share of 71.1% is thought by many, if not most reviewers, to be 5 to 10 points too high, particularly prejudicial to rural providers with wage indices well below 1.000. (Yes, the index is calculated to 4 decimal places—5 more than is valid.)"

"Reform Hospital Wage Index Use & Reclassification—As soon as possible, limit the use of the current wage index based on hospital wages to hospital services. Until a separate index is developed for other PPS services, the hospital wage area reclassification of hospital services should apply to all PPS services. CMS should allow hospitals that receive a three-year period of wage index reclassification to re-apply in each of the final two years of the original three-year classification period to avoid unexpected payment fluctuations. By allowing hospitals to apply in two of the three years, some of the year-to-year fluctuations will be accounted for and only those hospitals that show two straight years of lower costs will actually have to revert back to the original wage index classification."

"Provide A Medicare Managed Care Wrap Around For Cost Based Providers—CMS should provide wrap-around payments to rural health clinics (RHCs), federally qualified health centers (FQHCs) and Critical Access Hospitals (CAHs) for Medicare managed care services."

Help To Educate A Rural Workforce

"Fully Reinstate Rural Access To J1 Visa Waivers—The J1-Visa Waiver situation is a rural access to care issue. As such, the USDA should immediately reinstate the program, working with the INS to ensure security, and then the Department of Health and Human Services should assume responsibility as soon as the Department is prepared to properly oversee the program. It would be a sad irony if all of the positive work being done by DHHS to improve rural access was negated by the failure to act on this one single issue." (*The federal government has since announced their decision to do the above based on many protests from all parts of the country and Congress.)*

"Standardize Rural GME Guidelines—DHHS should standardize interpretation of Medicare reimbursement guidelines for rural GME. There exists no single source to which a program/institution may go for clarification. The rules are sufficiently complex to deter many teachers in rural areas, who could provide excellent educational experiences for residents and other learners, thereby increasing the likelihood of practice in rural or other underserved areas."

Stand Firm On DHHS Proposed Improvements In HIPAA Privacy Rule

"We strongly support the March 27th DHSS proposed improvements in the Privacy Rule. It represents an approach more consistent with what the vast majority of our rural patients and communities want and expect as we work to balance legitimate privacy needs and patient preferences with everyone's need for quality and cost effective systems."

Mental Health Major Challenge On The Farm

From "The Health, Mental Health and Safety of Wisconsin Farm Families, A Policy Paper for the Wisconsin Rural Health Development Council" by Roger T. Williams, Ph.D., Professor and Chairman, UW-Madison Department of Professional Development and Applied Studies. Made available at the Wisconsin Farm Health Summit, 4/3/02; the full text, including policy recommendations, is available at http://www.rwhc.com.

Chronic Stress For Farm Families

"When media attention dissipated following the 'farm crisis' of the 1980s, most people believed the farm crisis was over. Yet in Wisconsin, the crisis raged on. The plummeting land values of the 1980s were followed by a severe drought in 1988; feed shortages in 1989; low milk prices in 1990-91; a drought in 1992; floods in 1993; feed shortages in 1994; intense heat in the summer of 1995; a cold, wet spring in 1996; low milk prices in 1997; low beef, hog, soybean and corn prices in 1998-99; extremely low milk prices throughout 2000; and a cold wet spring followed by dry conditions in 2001."

"While not all Wisconsin farmers have experienced all of these stressors, most have experienced chronic, prolonged stress over a period of 15+ years. Farmers who are under stress for long periods of time encounter several effects from the distress, including the following:

Physical: headaches, backaches, ulcers, eating irregularities, sleep disturbances, frequent sickness and exhaustion

Mental: anxiety, anger, bitterness, sadness, loss of spirit, loss of humor, mental anguish and depression

Behavioral: irritability, backbiting, acting out, withdrawal, passive aggressiveness, alcohol or drug abuse, and violence

Cognitive: memory loss, lack of concentration, and an inability to make decisions

Self Esteem: feelings of inadequacy and failure—'I'm a failure,' 'I blew it' "

"The combination of effects will be different for every farm family member. But many experience a deadly combination of anxiety, sleep disturbances, exhaustion, anger, depression, substance abuse, withdrawal from others, as well as cognitive and self-esteem problems. It creates a situation where harm of self and others is a real possibility. The other common problem in farm families that have experienced chronic, prolonged stress is marital and family problems: the stress drives a wedge between family members, often leading to a downward spiral of less communication, more frequent fights and greater isolation within the family. This downward spiral is often accentuated when one or both spouses work off the farm to create a stronger cash flow situation for the family; the off-

farm job(s) drives the wedge deeper and communication becomes even more strained."

"While farm families may be experiencing problems, there are a number of cultural barriers that often keep them from reaching out for help. The **rootedness** of farm families (often the third or fourth generation of farmers on the land) can keep families from choosing a different career or life outside the community. The **work ethic** of families causes them to work longer hours, to milk more cows, to farm more acres and to take off-farm work to supplement their income; this workaholism limits their ability to link with helping professionals in the community. The pride, independence and **self-reliant spirit** of farm families keeps them from reaching out for help or limits helpers to a closely knit network of family and friends. The **attitude toward communication** causes families to hold things close to their chests since they don't want the 'community grapevine' to know about their problems. And the **traditionalism** of farm families often keeps them from making life or career changes that might be in their best interest."

RWHC Eye On Health

"Beyond network television – the Real Survivor."

Health, Mental Health and Safety Issues

"The health, mental health and safety issues of farm families are perhaps best told through stories. A farm family in central Wisconsin had experienced financial distress for a few years. In March, 1995, the farmer was milking 55 cows, cropping their 200-acre farm and working the second shift at a local factory. He was sleep deprived, exhausted and depressed when he was driving the neighbor's tractor home, fell asleep at the wheel, hit the ditch and flipped the tractor over. He crushed his pelvis and broke several ribs in the accident. His wife and their three teenage kids kept the farm running until they could sell the cows to allow for a long recuperation process. As he began to heal, he purchased more cows and went back into dairy farming. It's taken five plus years to physically recover from the accident but they have yet to recover financially. They had a basic catastrophic insurance policy at the time and have been struggling to pay off the huge deductible and other family and medical bills that piled up during the time of the accident."

"The health, mental health and safety issues of farmers can be summarized as follows:

1) **Exhausted and sleep deprived**: When under stress, farmers tend to work longer and harder, milking more cows, farming more acreage and often supplementing their farm income with off-farm income; as a result, they are often sleep deprived and exhausted and, thus, at greater risk for chronic illnesses and farm accidents.

2) **No health insurance or underinsured**: Many farmers, because they are self-employed, do not have access to high quality, reasonably priced health insurance policies; thus, a large number seek off-farm work for the sake of obtaining a good health plan **or** they go without insurance or settle for an expensive policy with high deductibles and high co-pays.

3) **At risk without disability insurance**: Farming, because of its link to animals, powerful machinery, inclement weather and heights, is more dangerous than most other occupations; this is a source of anxiety for farm families since they realize they are risking their lives on a daily basis and usually without worker's compensation to support them in situations where they may experience a disabling accident or illness.

4) **Don't seek treatment for minor accidents or chronic conditions**: Farmers who lack health insurance or who have high deductibles and co-pays are not likely to seek medical treatment for minor accidents and chronic conditions such as high blood pressure, diabetes, farmer's lung, milker's knee, melanoma, hearing problems, arthritis, bruises or broken bones (common problems for Wisconsin farmers); major accidents will take farmers to hospital emergency rooms regardless of whether they have insurance and these costs are absorbed by society and/or by patients with good insurance coverage.

5) **Don't seek counseling for mental health problems**: Farmers, because of their pride, independence and 'pull yourself up by your own bootstraps' philosophy, are reluctant to seek counseling for anxiety, depression, mental anguish, angry outbursts, alcohol abuse or other mental health or interpersonal problems.

6) **Counselors don't understand the farm culture**: Counselors and mental health professionals are often unfamiliar with the farm culture and insensitive to the powerful effects of long hours, the weather, low commodity prices and high levels of indebtedness; thus, they are often ineffective at working with farm families when families **do** reach out for professional help or their office hours make it difficult for farmers to seek help.

7) **Lack of access to doctors and hospitals**: The shift toward managed care has resulted in the demise of many small, independent rural physicians. And rising health care costs, chronic government under-funding, increased regulations, workforce shortages, dysfunctional regional competition and other factors, have made it difficult for small, rural hospitals to survive."

Partners in Agricultural Health

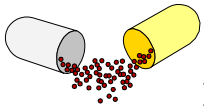
From "Rural Health-Care Providers Hope To Work Themselves Out Of A Job" by Gloria Hafemeister in the *Wisconsin State Farmer*, 2/22/02:

"Mary Brueggeman and Elizabeth Rosenthal work for Partners in Agricultural Health (PAH). Their goal is to work themselves out of a job. Partners in Agricultural Health works together with existing community and regional services and is focused on developing awareness of specialized services for farm-related health concerns. These include health education and health promotion programs. They also provide information on personal protective equipment such as respirators and information on how to get them and how to use them. Occupational health and physical examinations and screenings are also part of the program along with referral services."

"Through this program, rural people have an opportunity for first-responder training, first-aid training, programs detailing respiratory hazards on the farm and ways to prevent hearing losses for those who work on farms."

"Rural residents also have an opportunity to take part in various health-screening services such as hearing tests, lung function tests, height and weight evaluation, blood pressure screening, respirator education and fitness tests, cancer self-examination, and instruction on the proper techniques for lifting to prevent back injuries."

"Five hospitals, three public health departments and some other agencies currently work in partnership on the program. These include Adams County Memorial Hospital, Reedsburg Area Medical Center, Sauk Prairie Memorial Hospital Occupational Health Partners, Adams, Juneau and Sauk County Public Health Departments, Mile Bluff Medical Center and St. Clare Hospital. Supporting partners include the Southwest Area Health Education Center, Wisconsin Office of Rural Health and the Rural Wisconsin Health Cooperative." *The PAH Coordinators may be reached through RWHC at 608-643-2343. Funds are currently being sought to expand this pilot to all of Wisconsin.*



RxAssist is an on-line tool created to assist health care providers in locating sources of free pharmaceuticals for their uninsured patients. It is supported by The Robert Wood Johnson Foundation. The Web site contains a searchable database with up-to-date information on accessing more than 100 manufacturers' programs. Searches can be made by company name, brand name, generic name, or drug class to receive a list of matching programs. RxAssist is found at:

http://www.volunteersinhealthcare.org

Mainstream Hospital Journal Supports Parity

From an editorial, "For Mental Health Parity: Federal Legislation To End Discrimination In Coverage Is Long Overdue" by Todd Sloane in *Modern Healthcare*, 4/8/02:

"The time has arrived for a stronger federal law to end discrimination in health insurance coverage for the treatment for mental health disorders."

"A bipartisan coalition, led by Paul Wellstone (D-Minn.) and Pete Domenici (R-N.M.) in the Senate and Marge Roukema (R-N.J.) and Patrick Kennedy (D-R.I.) in the House, and including a majority of both houses of Congress, wants to pass a more substantial version of 'mental health parity' legislation this spring. The White House has been sending signals in the past few weeks that the president would sign a bill as long as it meets some basic criteria. Now the pressure is on House Republican leaders, who have been

the stumbling block on this issue, to stop delaying this much-needed change."

"Such a law would mean that anyone who offers mental health coverage could no longer place limits on that coverage that differ from the coverage of physical conditions, with an exception for treatment of substance abuse. The law would not apply to very small employers."

"The policy change would be critical for the estimated 20% of Americans who need such treatment at some point in their lives, many of whom face steeper copayments and deductibles than they pay for treatment of physical illness, as well as strict limits on the number of office visits or days in the hospital that will be covered."

"The change also would be important for the rapidly deteriorating network of mental health providers that has been hit by changes in payment policies and the closing of hundreds of inpatient facilities in the past 15 years."

"Congress passed a watered-down version of mental health parity in 1996. Though it was an important first step in addressing the problem of discrimination in health benefit coverage, access to mental health services remains limited. The 1996 law, which is set to expire this December, prohibits discriminatory annual and lifetime dollar caps for mental health benefits but left open considerable loopholes that allowed for far higher deductibles and coverage limits."

"Despite the protests of an industry group, a mental health parity law with teeth would actually lower overall employer costs. Depression is the leading cause of disability in the U.S., costing businesses more than $100 billion each year, various studies have found. New research suggests mental health programs with comprehensive benefits cut down on absenteeism and increase productivity."

"In direct costs, the bill pending before Congress would increase premiums for group health insurance by an average of 0.9%, at a cost of $23 billion over five years, according to the Congressional Budget Office. The CBO did not analyze the expected benefits in worker productivity from such coverage."

"Now, 34 states have some form of mental health parity laws, including 23 with strict requirements such as the proposed federal law. As Henry Harbin, M.D., chairman of the board of Magellan Health Services, the nation's largest mental health company, told a congressional panel last month: 'At Magellan we have yet to see an increase of greater than 1% of the total healthcare premium as a result of state parity legislation. Furthermore, we have found that these modest increases are similar for both large and small employers, and in rural, urban and suburban areas.' "

"For the well-being of all Americans, as well as the viability of the mental healthcare system, we need real parity in mental health coverage."

We Have More To Learn About Cooperation

From "United We Expand" by Henry Fountain in *The New York Times*, 4/21/02:

"In the coastal soils of southern Europe, scientists have discovered a supercolony of one species of ant, stretching 3,500 miles from Portugal to the Italian Riviera. It's the formic equivalent of the European Union, where the normal competitive barriers between ant nests have been dissolved — where every ant neighbor is a friend. It involves millions of nests and billions of insects, and is the largest cooperative unit ever found."

"What is even more remarkable about this discovery, which was made by scientists from Switzerland, France and Denmark and published this week in *The Proceedings of the National Academy of Sciences*, is the species of ant involved. It is the Argentine, an invasive bully of an insect, famous for aggressively taking over territory once it is introduced. Argentine ants are cut-throat — and cut-thorax and cut-abdomen. They like to rip their enemies' limb from limb from limb, and as often as not, those enemies are the Argentine ants in the next nest over."

"But the researchers tested ants from 33 nests around Europe, and found that when two from different nests were pitted against each other, about all that occurred was a little antenna-tapping — which is as close as Argentine ants get to being friendly. The results showed that in the 80 or so years since their introduction into Europe, the ants had managed to get over their aggressiveness toward their neighboring ants. This was true no matter how far apart the nests were."

"The researchers suggest that the ants' newfound mellowness may be a function of their very aggressiveness and their ability to prosper when introduced into an area. This quickly leads to more nests, closer together, which means more unfriendly encounters with the neighbors. The costs of defending a nest from all these fights may get to the point where it is no longer worth it. Instead, those nests that cooperate —

that have more members genetically disposed to accept outsiders as their own — will flourish. That genetic disposition becomes dominant over time."

"Of course, a genetic disposition to accept outsiders is not quite the same thing as trust. Perhaps it might better be described as a loss of the ability to distrust. Either way, it's better than what is going on above ground these days."

2002 RWHC Nursing Excellence Awards

Excellence in Nursing Management—Amy Hermes, a registered nurse since 1986, is the inpatient services manager at Stoughton Hospital, which includes the oversight of med/surg, intensive care, social services, care management and clinical operations. Amy is viewed as a leader by both her staff and peers for her willingness to "take the lead" on JCAHO compliance, customer service, and quality improvement. She has also been very involved with W-ONE and numerous wellness programs in her community. In addition to caring for three children, Amy is active with her church, Habitat for Humanity and the local Syttende Mai event.

Clinical Excellence—Linda McKee has been a registered nurse for almost 39 years and is currently employed in the Birth Center at Richland Hospital. Her past experience ranges from med/surg nursing and surgical recovery to OB nursing. Linda introduced childbirth classes to the hospital in 1975 and has served as both an instructor and resource to over 1,900 expectant parents ever since. She has also been involved with the development of other innovative programs in the areas of grief counseling, community outreach and patient advocacy. In addition to volunteering for numerous hospital committees, Linda is actively involved in the community. She plans on retiring in two years so she can spend more time with her husband and extended family.

The Nurse Excellence Awards were initiated by the nurse executives of RWHC's 28 member facilities to recognize the high quality of nursing practice provided by hospitals serving rural communities. Nurses in community hospital settings must be highly educated and well rounded in terms of clinical practice, in addition to having the ability to respond to a variety of age groups, diagnoses, and patient emergencies. The establishment of this award recognizes that excellence in nursing practice is a valuable asset to rural communities in the state of Wisconsin.

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