



Review & Commentary on Health Policy Issues for a Rural Perspective – November, 2008

Here We Go Again

This article by Emily Friedman was first published in Hospitals & Health Networks OnLine, 10/7/08. We are grateful for her permission to reprint it here:

"It's election time, and although experts had predicted that health policy would be front and center during the campaign, other issues have risen to the forefront of public attention: the economy, fuel prices and the usual array of character issues regarding the candidates. But the stakes for health care couldn't be higher, and if the health care community is going to be heard, its members need to know the issues."

"Ah, yes; our great exercise in self-government, the national general election. Our proof to the world that its oldest democracy still functions. Of course, that proof might get a bit lost in the coming month amidst all the mud-slinging, irrelevant side issues, uninformed press coverage, spinning, blogging and other attendant antics that this quadrennial event engenders."

"Also, this particular election offers the health care community some major challenges. A Kaiser Family Foundation poll in 2007 indicated that health care was the second overall public concern after the Iraq war (27 percent overall, with Democrats rating it as impor-

tant as the war and Republicans ranking it second). But an August 2008 Kaiser Foundation survey found that only 16 percent of the public cited health care as the top concern, ranking it fourth; for Democrats, it was third, and for Republicans, it was fifth."

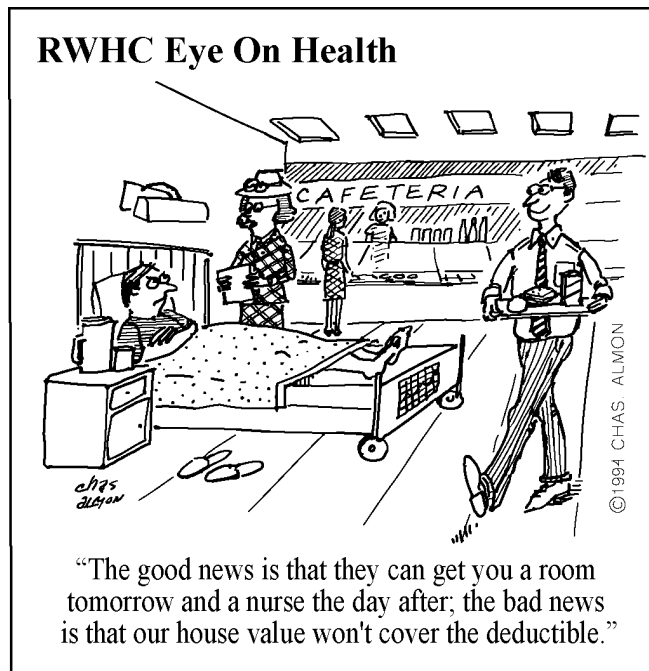
Keeping the Focus—"So if health policy is going to stay on the table as a priority in this election, it will

be necessary for health care professionals to press for its inclusion, despite the higher profile of inflation, fuel, unemployment and all the entertaining but unimportant topics that surface during any election campaign. Here are 10 health care issues that should be part of the election debate, no matter whom you are supporting."

The Issues—"Medicare. This program, which covers many of the health care costs of over 44 million people, is facing a serious

meltdown in that its own trustees predict it will go broke in 2018 or 2019. It will start paying out more than it takes in several years before that, just as the baby boomers are flooding into the program."

"Legislation passed this year will lower the (some say, excessive) payments that private Medicare health plans have been receiving for years, beginning in 2010. These savings are to be used to prevent a 15 percent cut in Medicare physician payments, in an environment in which many physicians are already requiring Medicare beneficiaries to pay extra 'fees'



of \$1,500 or more just to be allowed into their practices. Meanwhile, the Medicare health plans are fighting to keep the money. Who is going to get what part of the Medicare pie, and how much access beneficiaries will have, are key issues.”

Long-term care—“More than 9,000 baby boomers are turning 50 every day, and many of them are facing the unpleasant fact that their parents cannot live on their own, but have no long-term care insurance (and most of those policies are fairly useless, anyway). In many cases, these boomer families are also trying to pay for their kids’ college education. Nursing homes are appropriate only for the sickest of the sick, and assisted living is expensive, to say the least.”

“This country has no public policy regarding financing of long-term care for the frail elderly other than to allow those who have exhausted their resources (and often, they haven’t, but have hidden them pretty cleverly) to qualify for Medicaid; this group represents the largest portion of Medicaid spending, even though they are a minority of all beneficiaries. (Don’t get me started on how these greedy old people are stealing health care out of the mouths of low-income children; you can’t equate a healthy child with a demented 90-year-old in terms of how much it costs to provide care.) The fact is that terrible bargains are made every day in terms of how frail elderly people are cared for, ranging from warehousing in substandard conditions to bankruptcy to suicide, and I don’t hear anybody on the campaign trail even mentioning the issue.”

Medicaid—“One of the best-kept secrets in American health policy is that this is the largest insurance pro-

gram in the country—larger than Medicare—covering 48 million people. Its beneficiaries are a heterogeneous group, including low-income children and (usually female) parents, some pregnant women, persons with AIDS, some disabled people, low-income nursing home residents, low-income chronically ill in the community, Medicare beneficiaries who are too poor to pay their premiums and co-payments (by the way, there are 6 million of those folks—not a minor population) and other groups.”

“Diane Rowland of the Kaiser Commission on Medicaid and the Uninsured has described Medicaid as ‘a Christmas tree,’ and she’s right; it is responsible for covering all kinds of people, with this or that ornament dotting this or that part of the tree. The problem is that states pay a portion of the freight, sometimes as much as half, and when the economy goes soft, states have a tendency—perhaps I should say a predisposition—to cut the program. These cuts tend to take three forms: lower provider payments, restricted benefits and, if necessary, tossing people off the program. But even if a person can stay eligible, the fact is that in most states, Medicaid pays less than hospital costs, which doesn’t exactly make its beneficiaries the most popular patients in town. Many physicians—in some cases, most physicians, depending on the state—won’t accept Medicaid patients, and the situation with dentistry is worse, which led to a Medicaid-eligible 12-year-old in Maryland dying of an abscessed tooth that led to a fatal brain infection. No dentist would see him.”

“Given that most of these people are the poorest of the poor, they don’t have anywhere else to go. State and federal cuts in Medicaid have at least one inevitable result: more uninsured Americans.”

State Children’s Health Insurance Program (SCHIP)—“Most readers of this column are familiar with the SCHIP situation, given that I wrote about it earlier this year. The program was up for reauthorization, because it had only a 10-year run unless Congress renewed it. The Democratic Congress wanted to expand it; President Bush wanted to restrict it. Congress passed two bills expanding it; the president vetoed both. The vetoes were upheld. The program technically went out of business last September, but is limping along with emergency congressional funding at 2007 levels; that will expire in June 2009. SCHIP provides coverage to 6 million kids; if it goes

Rural Wisconsin Health Cooperative, begun in 1979, has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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away, the disenfranchised, uninsured population will increase by more than 10 percent—and they will be children, who have no say in the matter.”



Insurance generally—“There’s been a lot of talk lately—one might say a number of exposés—about the behavior of private insurers, especially in the small-group and individual market. To sum up a rather nasty business—and the severity of the problems depends on the state—commercial insurers (and some nonprofits) vigorously avoid those who are sick or disabled or might become so. Some insurers in California (and probably other states) sold individual policies to unsophisticated individuals and then denied payment if the policyholders filed claims, asserting fraud.”

“The insurers have been handed their lunch by regulators, and policyholders have been offered some restitution and even restoration of policies (I’m not sure I’d want one), but that does little good for the people who were bankrupted or whose care was terminated in mid-stream because their claims were retroactively denied; one of these policyholders was a woman being treated for aggressive breast cancer.”

“If we wish to have a pluralistic public-private market, policymakers must take a long, hard look at private insurance practices, and whether we want to continue to allow insurers to avoid the sick, injured and disabled. I would add that with genetic testing becoming more common, the future looks even more glum, unless policymakers intervene.”

Health care workforce—“This is a difficult issue; I must say, I do wonder, when the average medical school graduate leaves school carrying \$140,000 or more in debt, where all the federal funding for medical education goes. I also wonder why nursing school faculty are so underpaid that few want the job, while qualified applicants for these schools are turned away for lack of teachers—in a nation where the health care profession that faces the greatest future shortage is nursing.”

“To what use, exactly, is all the federal and state funding being put as it disappears into the giant maw of health professions education? Nonetheless, if we want young people to choose nursing and primary care (and the most recent survey found that only 2 percent of

medical students want to go into primary care), then students (and in some cases, faculty) should be getting financial support before they all head for cosmetic surgery and dermatology.”

E-health—“Needless to say, this topic is a whole article—if not a book—in itself, but I’ll just hit the high (or low) points. Health care is moving toward (we hope) an interoperable system of electronic data collection, storage and sharing. Already, we have electronic health records, personal health records, community health information data banks, e-prescribing and more. Will this make health care easier and more efficient? For payers and providers, of course, yes. For patients? Well, maybe. But along with this revolution (and it is one) come some serious concerns, among which are: What about privacy of personal medical information in a basically unregulated private insurance market? How will we lace together all the different systems that are up and running? What about competing and conflicting standards? How are small medical practices and clinics and rural hospitals and distressed safety-net providers supposed to pay for all this? And what will be done about those providers who won’t get with the program, and those insurers and employers who ‘mine’ these databases to weed out bad risks? Who’s in charge here? No one seems to be minding the store.”

Market issues—“These aren’t new, but that doesn’t mean they aren’t vexing. To what degree should unbounded competition control health care? What about corruption and profiteering in both the for-profit and nonprofit sectors? Why are the penalties for those who violate the few existing rules so minor? Should insurance executives be able to personally earn hundreds of millions of dollars simply by selling policies in a country where nearly 50 million people lack coverage? What about waste? What about fraud? What is the proper role of the market in this sector?”

Nonprofit tax status—“For nearly five years now, nonprofit hospitals have been under the gun from a variety of critics over a very simple issue: How should low-income uninsured patients be treated? Should they be forced to pay billed charges? Should their homes and farms be forfeit? How much interest should they be charged? What should a hospital or health system be required to do to retain nonprofit status? Should the

amount of free care provided to truly poor uninsured people be the standard, as it once was? Many people thought, when Iowa Republican Sen. Charles Grassley, who has vigorously pursued this issue for years, lost chairmanship of the Senate Finance Committee to Democrat Max Baucus of Montana, that the discussion would end.”

State and local issues—“Most news media focus on the national election picture, and even local media are more interested in congressional and municipal elections than in health care issues on the local level. But the fact is that many of the issues I have discussed here do come down to the state and local level, from efforts to broaden coverage to providers’ tax status to whether such-and-such a provider is going to get an easement to whether a safety-net hospital or clinic is going to be allowed to go up the flume. It is much more difficult to get information on these more localized issues than on the vague generalities of national health policy platforms, but in the end, they may affect you more than who gains the White House or control of Congress.”

“The future of American health care is riding on this election, even if the candidates are busy talking about less difficult things. It is our job to get them to talk about what will happen to our system and its patients, whether they want to or not. The issues are complex and not easily explained; the special interests are many; the stakes are incredibly high. But if our concerns are not part of the debate because we did not see to it that they were, then we have no one to blame but ourselves.”

“And by the way, if you don’t vote, you have no right—no right—to complain about what happens.”

RWHC ITN “First in the Country”

The Rural Wisconsin Health Cooperative Information Technology Network (RWHC ITN), based in Sauk City, has become the first FCC Rural Healthcare Pilot Program network to receive a funding commitment

17th Annual Monato Essay Prize Now \$2,000

A \$2,000 Prize for the Best Rural Health Paper by a University of Wisconsin student. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at

<http://www.rwhc.com/Awards/MonatoPrize.aspx>

letter (FCL). The FCC Pilot Program, a first-of-its-kind federal health care network initiative, will be distributing up to \$400 million dollars over 3 years.

This announcement comes nearly a year after the FCC released the *Rural Health Care Pilot Program Selection Order*, which identified 69 projects from 43 states that qualified for funding based on Pilot Program goals to stimulate deployment of broadband networks necessary to support innovative telehealth and, in particular, telemedicine services to areas of the country that need them most.

The RWHC ITN FCC project provides high speed, redundant broadband connectivity initially to 4 critical access hospitals, 2 physician clinics, and 2 collaborative datacenters that are participating in a cooperative hospital information system and electronic health record initiative.

“By collaborating on health IT,” says Louis Wenzlow, ITN’s Chief Information Officer, “the participating facilities are able to work together to implement EHR systems, to share their server and datacenter costs, and to benefit from the expertise of a pooled support staff. Ultimately, the communications infrastructure supported by the FCC Pilot Program is what makes our shared datacenter model possible.”

Vendors that will be providing aspects of the ITN FCC project include CenturyTel, Charter, and Digi-corp. “We’re managing the network ourselves,” Wenzlow said, “so we don’t need to rely on a single vendor for the entire project. As we build and expand, the vendor selection question will always be who can provide the most appropriate and cost effective solution for the location being added.”

The hospitals and clinics participating include: Boscobel Area Health Care, Memorial Hospital of Lafayette County, St. Joseph’s Community Health Services, Tomah Memorial Hospital, and two physician clinics in Wonewoc and Elroy. Wenzlow hopes the Pilot Program, which pays for 85% of eligible costs, will eventually be expanded to provide funding for additional participants. *For more info, contact Louis Wenzlow at 608-644-3237 or lwenzlow@rwhc.com*

Rural Pharmacy Rotations Pay Dividends

Eye On Health asked Michelle E. Farrell, RPh, PharmD, Bohlman Pharmacy Services, in Boscobel, to briefly talk about her clinical experience as a pharmacy student and how it led to her choosing to practice in rural Wisconsin:

“My path to a rural pharmacy practice at Bohlman Drug in Boscobel was a fortunate one. I grew up on a small dairy farm outside Mount Hope in rural Southwest Wisconsin. Upon my fourth year of pharmacy school, I thought I would stay in Madison or Milwaukee and complete a residency—little did I know how a January rotation in Boscobel would change my mind.”

“Why did I go to Boscobel for a rotation? Honestly, I knew little about it other than the mentions of Bohlman Drug throughout pharmacy school. It was 16 miles north of my parent’s home in Mount Hope. I knew the hospital pharmacist in town through my Grandfather’s fishing buddy. The rotation offered free housing and a myriad of potential experiences—Ambulatory Pharmacy, Long Term Care, Infusion, Osteoporosis Screening, Immunizations, etc.”

“Over the course of the rotation, I was re-immersed in small town living. I went to high school basketball games. I enjoyed dinner with my parents and old friends. I assisted my significant other at his dental practice in a neighboring small town. I helped my family prepare for their farm sale. All I would have forgone had I lived in Madison. I was reminded of the things important to me—no traffic, fewer distractions, and more time with the people I care about the most.”

“I’m happily pharmacy variety-oriented and I loved the experience in Boscobel so much that I accepted a position. That was eight years ago; I’m now proud to

say I serve as pharmacy owner and manager. I coach high school basketball. I’ve been close to home and been with my family through many things I would have missed had I remained in Madison. I have been blessed with many rewarding experiences.”

“As I precept pharmacy students, I try to impress upon them the joys of practicing close to home and the challenge and reward of rural practice. I encourage other rural pharmacists to share in the development of rural providers. They’ll be glad they did.”

UW Promotes e-Learning for MDs

The University of Wisconsin’s Office of Continuing Professional Development in Medicine and Public Health has an on-line continuing education well worth exploring at: <http://www.ocpd.wisc.edu/>

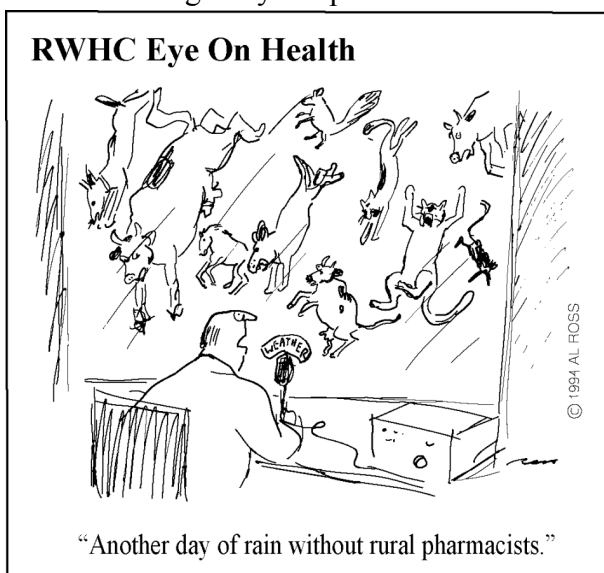
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E-learning courses are an effective way to gain new knowledge, build on your skills, and keep current with new techniques and procedures. Our courses are designed to provide an effective and interactive way to support life-long learning goals of health care professionals worldwide.

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- ✓ Learn from experts in the field.
- ✓ Improve your practice and gain real world skills.
- ✓ Most courses are FREE for viewing."

"All CME credit courses are peer reviewed by physicians from the UW School of Medicine and Public Health and accredited by ACCME."

Wisconsin AHEC Centers Nearly Double

From the Wisconsin AHEC System Office, 10/08:

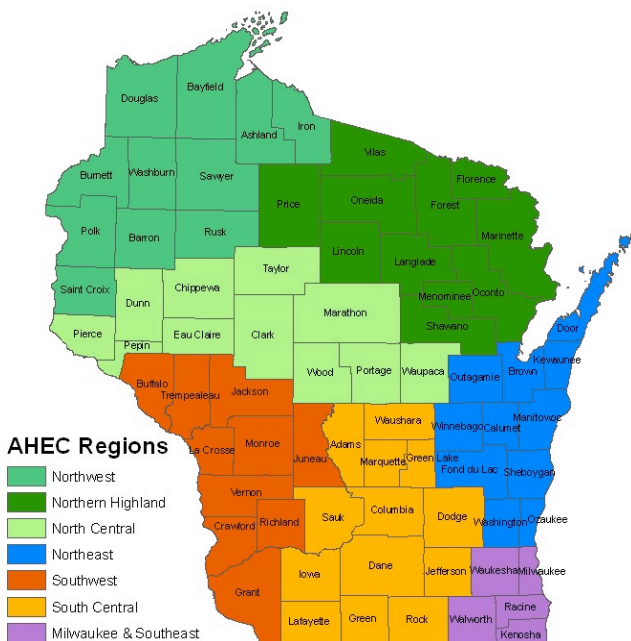
"The Wisconsin Area Health Education Centers program has been awarded a renewal of its Model AHEC grant for 2008-2011 through the Department of Health and Human Services, HRSA, Bureau of Health Professions. The AHEC Program is one of the federal Title VII health professions programs. The award will total over \$1.7 million for the three-year period. The exact amount is determined annually, and has been set at \$574,772 for 2008-09."

"The statewide AHEC program is directed by Nancy Sugden, Assistant Dean, Academic Affairs, University of Wisconsin School of Medicine and Public Health. The UWSMPH supports the operation of the AHEC Program Office in Madison. Over 75% of the federal funding received goes to programs sponsored

by the regional AHEC offices in support of community-based education of health professions students, health careers educational activities for pre-professional students, continuing education for practicing professionals, and health education outreach activities conducted in partnership with community agencies. The Centers partner with the UWSMPH and the UW System campuses in their regions, as well as the Wisconsin Technical College System campuses, private colleges and universities, local health departments and other agencies."

"The renewal included approval for federal funding of three new centers, nearly doubling the size of the program. Two of the original four centers will remain unchanged: **Milwaukee AHEC** serves a 5 county region in southeast Wisconsin. **Northeast Wisconsin AHEC** (located in Manitowoc) serves an 11 county region along Lake Michigan and the Fox River Valley, including Door County and the cities of Green Bay, Appleton, Oshkosh, Sheboygan and Fond du Lac. The former Northern AHEC has divided into three centers, each serving 11 counties: **North Central AHEC**, located in Wausau, **Northwest AHEC**, located in Ashland, and **Northern Highland AHEC**, with offices planned in Marinette and Lac du Flambeau. The former Southwest AHEC has divided into the 10 county **Scenic Rivers AHEC**, with an office in Cashton, and the 13-county **South Central AHEC**, with offices in Madison."

"The UWSMPH community is thrilled to have this opportunity to expand its programs and its partnership with the AHEC Community."



Rural Wisconsin Health Leaders Honored

Two longstanding RWHC Board members were honored at the WHA Annual Convention in Green Bay:



Stan Gaynor—"Partners of WHA is pleased to present its 2008 Best of the Best Administrative Award to Stan Gaynor, chief executive officer of Black River Memorial Hospital in Black River Falls, Wisconsin. This award recognizes an on-site

hospital executive who demonstrates a cooperative, supportive, enthusiastic, and well-defined relationship with the volunteer organization.”

“In nominating Stan for this award, the Partners of Black River Memorial Hospital members stated, ‘Our CEO is very visible and involved with our volunteers.’ Upon Stan’s arrival at Black River Memorial Hospital, he ensured that the Partners group became ‘a visible part of the printed hospital Organization Chart’ with the volunteer services manager reporting directly to him, as CEO. He continues to give the Partners group visibility throughout the community by including a Partners report in the hospital’s printed Annual Report, allowing the Partners president the opportunity to give a verbal report at the hospital’s Annual Meeting, and supporting and encouraging the hospital’s public relations manager to continually promote Partners events through news releases, advertising, posters, and professionally designing and printing the Partners newsletter.”

“Since his arrival, Stan and his wife have been dues-paying members of the Partners of Black River Memorial Hospital, and he regularly participates in Partners activities, especially the fundraisers, from cleaning up following an event, to unloading merchandise for the annual garage sale, to performing in the variety show, to encouraging and driving Partners to Madison so they can participate in WHA’s Advocacy Day.”

“The Partners group also shares that he consistently ensures they have the financial support needed, from a budget line item in the volunteer services manager’s annual budget, to sending members of the Partners group to the Partners of WHA’s annual convention each fall. The Partners of Black River Falls are proud to work each day with the overwhelming support of Stan Gaynor, stating ‘To us, our CEO has been one of our best cheerleaders!’ ”

Harold Brown—“WHA is proud to present the 2008 Lifetime Achievement Award to Harold Brown, chief executive officer of Prairie du Chien Memorial Hospi-

tal. Harold has more than 40 years experience in health care, including hospital, home health, hospice, clinic and education settings. Under Harold’s leadership, Prairie du Chien Memorial Hospital was the recipient of the Wisconsin Children’s Trust Fund Award and recipient of the Governor’s Exemplary Employers Award.”



“In addition, Harold has received many personal awards for his leadership. This includes ‘The Louis Gorin Award for Outstanding Achievement in Rural Health Care’ and ‘Volunteer of the Year Award,’ given by the National Rural Health Association, as well as their first ever ‘Lifetime Achievement Award,’ recognizing an outstanding career in service to rural health care. He also received the 1988 ‘Distinguished Service Award’ from the Wisconsin Hospital Association.”

RWHC Eye On Health



“I’m humbled by this honor and best of luck to you suckers who can’t retire.”

“He has also served in various capacities for many organizations. He was a member of the AHA House of Delegates representing the Small and Rural Hospital Constituency Section and a member of the AHA Small and Rural Hospital Council. He has also served Shared Health Services Corporation, HMO of Wisconsin, Unity Health Plan, Community LLC, and Wisconsin Rural Health Association as an officer and/or board member. He also served as president of the National Rural Health Association and as director of their Hospital Constituency Section.”

Hospital Promotes Health to 3rd Graders

Monthly, Eye On Health showcases a RWHC member story from the Wisconsin Hospital Associations’ annual Community Benefits Report. Wisconsin hospitals provide over \$1.3 billion in community benefits; twice that if you include Medicare shortfalls and bad debt.

This month's feature is about St. Clare Hospital & Health Services' (Baraboo) "Rainbow" Program:

"One of the goals of the St. Clare Health Care Foundation is to give back to the community as often and in as many ways as possible. One of those ways is through free health and wellness education, offered through what the Foundation calls Pathways to Wellness Seminars. Many of the seminars and programs are developed for a broader, more adult audience. One of the programs, however, is aimed only at third grade students: Eating from the Rainbow."

"Eating from the Rainbow is an original production about the benefits of eating a rainbow of fruits and vegetables and being physically active. It was conceived, created and written by the Foundation's Pathways to Wellness Seminars Committee."

" 'We developed this 30-minute program as a fun and interactive way for children to receive the necessary tools to select foods wisely and get physically active,' explained St. Clare Health Care Foundation Director

Keri Olson. 'In light of the increasing rate of childhood obesity, the Committee decided that one way to help our community was to work with elementary school-age children so that they can begin developing healthy habits for life.' "

"The presentation was piloted in March 2007 to approximately 250 third grade students in Baraboo's public and private schools. After receiving rave reviews from teachers and students, the Committee revised the script to include even more student participation and a list of activities for the teacher to incorporate into the class's curriculum."

"The program, featuring main character Roygie Biv (an acronym for the first letter of each color of the rainbow) played by St. Clare Hospital Clinical Dietician Lisa Krayner and children from each classroom dressed as fruits and vegetables, was presented in Baraboo third-grade classrooms throughout the 2007-08 school year. Students receive free samples of fresh fruits and vegetables, a Fruits and Veggies-by-color Pocket Pal, and a 'Fitness is Fun' pledge card."

Rural Health Policy Institute—This Year, Be There!
January 26-28th, 2009 Washington DC
Info at: <http://www.ruralhealthweb.org/>

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