

Review & Commentary on Health Policy Issues for a Rural Perspective – May 1st, 2003

Rural Hospitals & FQHCs Form Alliance

The twenty-eight rural hospitals who own and operate RWHC are partnering with the Wisconsin Primary Health Care Association, a nonprofit association of 15 Federally Qualified Health Centers and two tribal clinics to “jump start” a particularly innovative telehealth project that will build on the current capacity of RWHC’s Wide Area Network—a secure, frame relay network suitable for a wide range of telehealth applications.

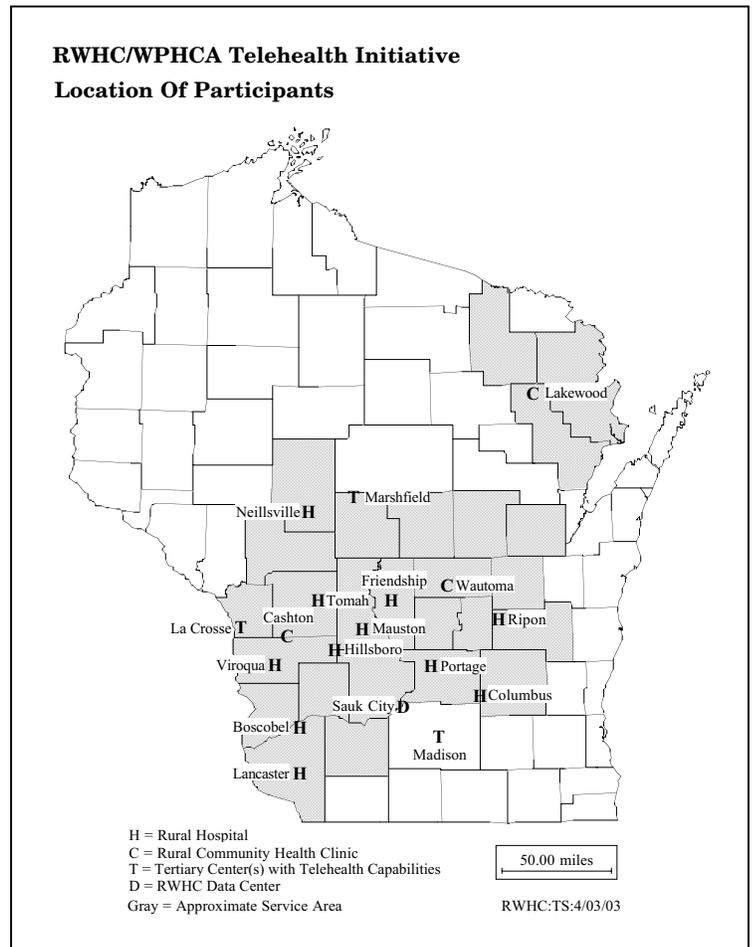
Purpose & Background

The RWHC/WPHCA Telehealth Initiative initial participants include eleven rural hospitals and three health centers. The goal of the Initiative is to “help rural communities build the human, technical and financial capacity to develop sustainable telehealth programs”; its objectives are as follows:

- 1) Connect the three clinics and four of the eleven hospitals not already connected to the RWHC Wide Area Network, enabling all of the Telehealth Initiative’s participants to access the proposed, shared telehealth services and applications.
- 2) Improve compliance and outcomes involving patients with chronic conditions through communication, education and remote consultation with specialists, thereby reducing inappropriate clinic visits and hospital readmissions by 10%.

- 3) Increase reimbursement and revenues to rural providers 5% through a wide range of shared health information/business services.
- 4) Apply resulting cost savings to providing direct patient care services and sustaining telehealth applications beyond the scope of the grant project.

In 2001, RWHC partnered with the Wisconsin Office of Rural Health, the Wisconsin Health & Hospital



“If we continue silent as more and more ‘profitable’ activities are carved out of community hospitals, should we complain when they drop the services that are currently being subsidized—charity care, emergency rooms and primary care clinics, to name a few?” Editor RWHC *Eye On Health*, 4/14/03

Association, and the State's Critical Access Hospital Coalition in assembling a team of telehealth experts (Health Tech Strategies in McLean, VA) to assess the potential for rural providers in Wisconsin to pursue telehealth applications.

The study was called the "*Rural Wisconsin Telehealth Project*". The project consultants focused on facility/community needs, existing resources, and potential barriers, and came to the conclusion that there would be immediate and tangible benefits to pursuing telecommunications/telehealth projects, if the participants were to collaborate and share resources.

Based on these recommendations and a second feasibility study funded by a targeted consultation grant through AcademyHealth; formerly AHSRHP, RWHC methodically designed and built a secure, high-speed data network that member hospitals could use to access a broad range of shared telehealth and business applications. This has provided a solid start, but the real potential for helping rural communities build the human, technical and financial capacity to develop sustainable telehealth programs are inherent in the *RWHC/WPHCA Telehealth Initiative*. Current participants have found it difficult to "go to the next level" due to start-up costs, associated fees, and/or a lack of equipment/expertise.

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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The prior consultants' recommendations were used as a blueprint for planning/implementing the RWHC Wide Area Network and will be carried over to the planning and initial development of the *RWHC/WPHCA Telehealth Initiative*. The rural landscape is littered with the remains of prior telehealth projects that crashed and burned due to a lack of planning or infrastructure. This project will benefit from the lessons learned (and mistakes made) in those previous efforts. These issues may be broadly categorized into those relating to technology, human and organizational matters, and medical-legal issues.

The Challenges

Perhaps the biggest technical challenge facing the implementation of a telehealth network is access to "broadband" services. Increased bandwidth is important to all of the applications being proposed in the *RWHC/WPHCA Telehealth Initiative*. Some clinical consultation and teaching applications may require real-time transmission of video or which generally require higher bandwidth support. For example, full-motion, compressed video is best achieved at bandwidths around 384 Kb/s, which is well beyond the current capabilities of some of the participants in this project.

At the same time, health care information for providers or consumers may be transmitted at today's Internet speeds. For many of these applications – such as at-home access to wellness and disease prevention information—dial-up or dedicated line access through local Internet Service Providers (ISPs) would be sufficient.

Based on conversations with hospital technical staff and representatives of local telephone exchanges, it would appear that faster services such as cable modems are becoming more available in the small towns representative of this project. However, use to date is limited, and experience in other areas show that many problems and limitations have emerged with this still relatively new technology. Most of the hospitals involved with this project already have full or fractional T1 capacity via the RWHC Wide Area Network.

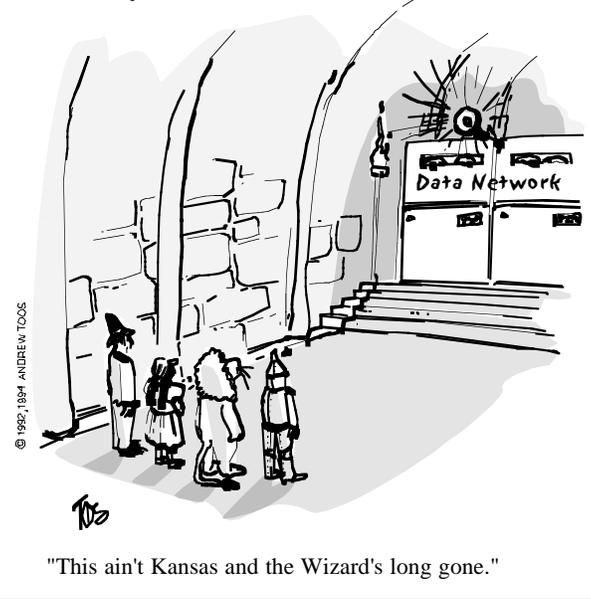
Given the range of networking and service options available to rural providers, another important issue to consider when selecting network architectures has to do with what is known as “interoperability” or the ability for otherwise disparate systems to exchange information with each other. It is critical that vendor systems use “open standards” which allow them to communicate with each other.

A second design issue has to do with varying bandwidth capabilities among the project partner institutions will have to do with the functionality of systems and the applications which ultimately get adopted. The project’s network administrator will make sure that participating hospitals, clinics, physicians, and home/community access points share a common level of system availability. It is important that system features selected are readily available to all users in all locations. A third issue which will be considered when selecting systems and vendors is the related issue of scalability. Systems that “scale” have components that work equally well in small or large settings (i.e., on a doctor’s personal computer or the workstation of a mainframe computer).

Access to the Internet is variable—some of the hospitals/clinics reported as few as seven connections, others between 10-20. Internet access was reportedly being used to do research and literature searches, order supplies, and check on regulatory compliance with various governmental agencies. Other department representatives were using the Internet to stay current in their fields, and to explore what kinds of technologies might benefit their departments.

Among the major barriers to the robust and sustained implementation of telecommunications and telehealth projects in rural areas are a series of “human dimension” issues having to do with the respective organizations. These include patient/provider acceptance of

RWHC Eye On Health



technologies, willingness to provide services and information at a distance, potential disruption of established referral patterns, and lack of reimbursement. The success of the *RWHC/WPHCA Telehealth Initiative* will depend on the degree to which the administrators, patients, physicians and other providers favorably view the potential benefits in terms of improved care, access to services, and/or financial gain.

These organizational issues will be addressed in the con-

text of the project’s overall planning process, as part and parcel of the long range goals and objectives of the individual sites and their respective communities. Moreover, individual practitioners must be assured that their ability to make treatment decisions will not be threatened but will be enhanced by the added knowledge that can be gained through access to advanced telecommunications as a part of their practice.

To address these system design and human challenges and achieve the previously stated project goals, RWHC and WPHCA are seeking funding through a variety of federal sources to enhance the capacity and infrastructure of the RWHC Wide Area Network, so participating rural providers (and their patients) can access a wide range of telehealth services. The proposed applications include: patient-to-provider and provider-to-provider communications, distance education and training, real-time remote video consultation, and shared healthcare information/business services.

These services will be provided through new and existing relationships with regional health centers, medical schools, state agencies, and service corporations. Over time, the project participants can pursue more advanced telehealth applications such as telerradiology and remote patient monitoring. The required technology and bandwidth are already in place through the RWHC Wide Area Network, which gives

this initiative a distinct advantage. Federal financial support will allow the hospitals and clinics to select from a menu of much-needed telehealth applications that will dramatically improve the quality of health care in medically underserved areas of rural Wisconsin.

Supreme Court Allows For Fair Competition

From “Supreme Court Upholds ‘Any Willing Provider’ Law” in *Business First of Louisville*, 4/2/03:

“In a unanimous ruling, the U.S. Supreme Court upheld a Kentucky law that forces health maintenance organizations to let ‘any willing provider’ into a company’s medical care network.”

“The law was first adopted in 1994 and amended in 1998. It says HMOs ‘shall not discriminate against any provider who is located within the geographic coverage area of the health insurer and **is willing to meet the terms and conditions for participation established by the health insurer**’, according to an opinion written by Justice Antonin Scalia.”

“The Supreme Court ruling affirmed a lower-court ruling by the 6th U.S. Circuit Court of Appeals in Cincinnati. In upholding the law, the justices rejected arguments by Kentucky Association of Health Plans Inc. that Kentucky’s law was preempted by the federal Employee Retirement Income Security Act of 1974. The HMO association also had argued the law didn’t amount to regulation of the insurance industry because it regulated the interaction of patients and medical providers rather than insurers and medical providers.”

“In the court opinion, Scalia wrote, ‘We find neither contention persuasive. We do not think it follows that Kentucky has failed to specifically direct its any willing provider laws at the insurance industry.’ ”

“Janie Miller, commissioner of the Kentucky Department of Insurance, said in a news release that she was pleased by the decision. ‘We believe this is

an important consumer protection,’ she said in the release. ‘Not only does it allow patients to maintain relationships with their doctors but it increases access to providers for those in rural Kentucky.’ ”

Note: About half of the country’s fifty states currently offer some type of “any willing provider” consumer protection, Some states have addressed a narrower



Senator Dale Schultz Honored With 2003 Health Care Leadership Award By Wisconsin Hospital Association

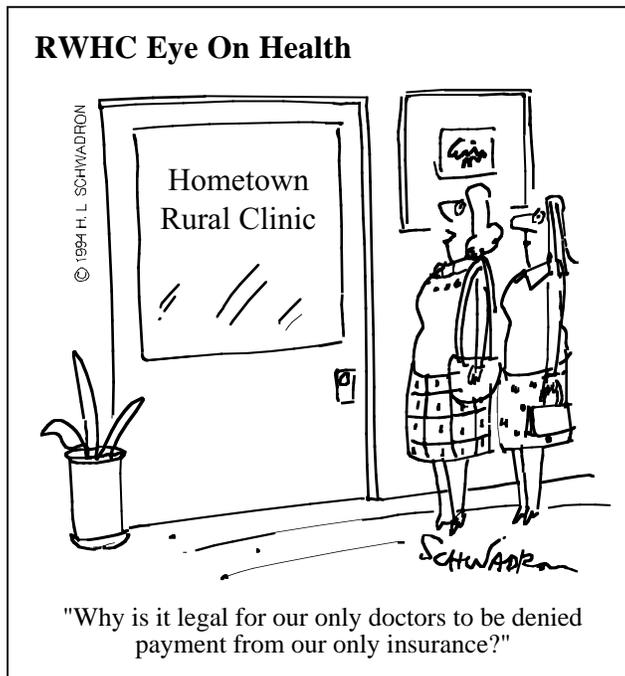
Bobbe Teigen, CEO of Sauk Prairie Memorial Hospital, presented the WHA 2003 Leadership Award to Senator Dale Schultz at WHA’s Annual Advocacy Day in Madison on April 8th. Dale’s district comprises most of southwest Wisconsin, including nine RWHC hospitals. In his over twenty year legislative career, Dale has always made rural health care a top priority—as Bobbe reminded us, “Dale supported rural health long before rural health was fashionable.”

He is a tireless advocate for his constituents, never shying away from the tough issues. Early last year, when regional blood services were proposing to nearly double their prices for rural hospitals, Dale took the issue head-on. Dale championed creation of the Rural Health Development Council, and he has been a major supporter of many of its initiatives, including:

- Refocusing the state’s two medical schools towards graduating more primary care physicians and placing more of them in rural areas.
- Working to end Medicare payment disparities in rural areas.
- Creating a loan forgiveness program for physicians, NPs, PAs and CNMs locating in rural/urban underserved areas.

Thanks to a good friend!

set of circumstances typical of rural communities. For example, Minnesota gives about 100 clinics and hospitals and other 'essential community providers' the right to be included in any health plan's network at comparable rates."



Insurance Self-Advocacy Guidebook On-Line

From the 100-page *Health Insurance Guidebook, Your Family's Guide to Advocating for Your Child With Special Needs* by Bobby Peterson and ABC for Health, Inc. at <http://www.safetyweb.org/>:

"The United States has many of the world's most sophisticated medical facilities and our doctors and scientists have developed treatments for everything from rare forms of cancer to innovative treatments and therapies for autism. As a nation, we spend more money on health care than any other nation in the world. Sadly in our marvelously advanced health care system, the people with the greatest ongoing need for services are often those who struggle the most to maintain affordable coverage and care. In particular, families of children with special health care needs may steer around seemingly impassable layers of red

tape in search of needed health coverage and care because the 'system' is so complex. Parents cannot access the services their child needs simply because they lack information and help negotiating the system. Consequently, they can feel isolated, bewildered, frustrated and often angry."

"Why can getting your care covered and paid for be so difficult? There are two major reasons: strategies by insurers to control the cost of health care and the fragmentation of our health care system between many different systems both public and private. As a consequence getting health coverage for an ongoing or chronic illness is like running a marathon: a test of your grit, determination and just plain endurance."

"Moreover, insurance, through the principles of managed care, has virtually transformed itself over the past two decades. Make no mistake about the future either as we are certain to see more change as medical advances in drugs and technology, drug-resistant viruses, and an uncertain economy continue to transform our ideas about health insurance and coverage. New language and new types of coverage continue to emerge while the medical treatments grow more and more sophisticated and more and more expensive. All of these factors working together can create an intimidating atmosphere for you as you negotiate an ever-changing system."

"The good news is that with the basic background in this book, you can approach your health coverage options with more confidence. Whether you are selecting health care coverage, using your existing coverage or challenging a decision made by your insurer, a sound understanding of insurance and how it works will help you get what you need and deserve for your family."

"Although many people have felt both the sting of an insurance denial and sensed that their denial was unfair, few people realized that the same denial was possibly illegal. Or, in fairness, the denial might have been a simple clerical error. In all large bureaucracies, like insurance companies, there are ample opportunities for mistakes, errors and yes, illegal actions that will go uncorrected unless you speak up and assert your rights as a policyholder."

“Typically, the most common problems experienced by health consumers can be avoided by taking a proactive and preventive approach to understanding and using health insurance coverage. This book is designed to help even the odds for you by laying out the basic principles of insurance. With that knowledge under your belt, we show you how to evaluate your insurance options so that you can make informed decisions about your coverage. You’ll learn when and when not to switch your health coverage, and what laws you’ll need to know as you choose. You’ll discover some of the reasons behind claims denials. By understanding how claim decisions are made, you will be better equipped with the tools to prevent them in the first place. And if you do end up being denied care, we will show you how to develop the paper trail to marshal the evidence and other resources you need to craft a successful appeal.”

“While the information in this book can be helpful, for many it may come too late. Tens of thousands of American families are already burdened by oppressive medical debt and the additional harassment and hounding from collectors. But just because you have medical debts does not mean you forgo basic rights and the protection of the law. With knowledge of your rights, you could keep your creditors at bay while you work to overcome your medical debt. You will also learn about important programs that can supplement or even replace your private insurance. With a detailed understanding of the health care coverage landscape, you will become your own strongest supporter and be able to deal with your insurer in a language they will recognize and understand.”

“Will your insurer cover everything you need whenever you want it? Quite simply the answer is no. However, with persistence and a bit of savvy you can have a substantial positive impact on the quality of the health care received by your family.”

Note: *Tackling the Uninsured Puzzle: Collaborating for Community Care* is a related and excellent resource, written from the clinic’s perspective. The authors are Jeanan Yasiri at Wisconsin’s own Dean Health System and Thomas H. Blinn at the Sutter Physicians Alliance in California.

**The Rural Wisconsin Health Cooperative
Congratulates Our Very Own
HAROLD W. BROWN
On His 30 Incredible Years
As Chief Executive Officer
Prairie du Chien Memorial Hospital
Home Health Agency and Prairie Hospice
Prairie du Chien, Wisconsin
April 2nd, 2003**

“What if you could provide care to everyone without health insurance? You can’t handle the task alone, but you can be an agent of change by taking the lead and spurring others to activity. Yasiri and Blinn spotlight community-based collaboratives that have brought together health care providers, consumers, competitors, political representatives and social advocates to address lack of access to health care.”

This 200-page paperback can be ordered on line <www.mgma.com> with all of the authors’ royalties going to the Madison Community Health Center.

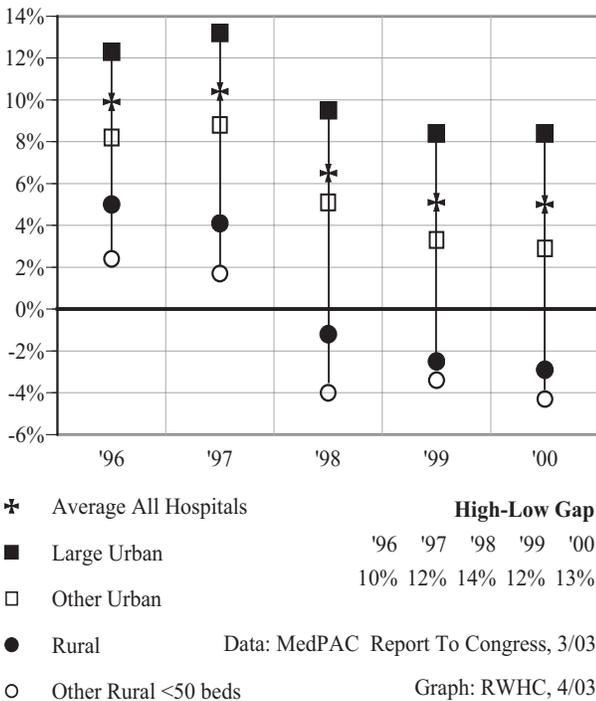
How Do We Address Competition’s Dark Side?

From Glen Grady’s newsletter at the Memorial Medical Center (Neillsville, Wisconsin), 3/03:

“Financing community health care organizations is a complicated issue. It is something that is very important to all of us yet the way we are financed is a mystery to many if not most of those that work in health care. With that in mind we had Rich Donkle and Dale Gullickson from the Rural Wisconsin Health Cooperative give a four hour seminar on March 19th to our managers and supervisors on the subject of how to read healthcare financial statements.”

Medicare Rural-Urban Inequity Goes From Bad To Worse

Overall Medicare Hospital margins incl. payments for direct graduate medical education by hospital group, 1996–2000



new equipment, but our original missions were to provide health care service to our communities. Memorial’s mission statement, ‘together, through quality, accessible health care, a better community’ is reflective of many community hospitals and long term care facilities in Wisconsin, as well as some of the state’s larger physicians clinics.”

“Recently, however, a few of Wisconsin’s health care organizations have started acting like they have lost sight of their community-based mission and have begun concentrating on high profit margin services that have little broad community application. For instance, facilities that do just outpatient surgeries and do not cover a broad range of medical problems and do not have twenty-four hour emergency room can be very profitable. They only have to staff for a certain number of hours and with certain medical and pharmaceutical supplies and equipment because they know what type of patient is coming through their door. The patient has been scheduled and the procedure to be performed has already been diagnosed.”

“Financial statements are funny. We all run at least one of our own in our check book, but in health care, very few people have an in-depth understanding of just what each line item might mean and how it affects other line items and the total operation in a health care organization’s budget. I’m sure that none of us came out as a total expert, but I believe the class will help everyone cope with the questions I am constantly bombarding our managers with concerning their particular department’s operation.”

“During the presentation, some very interesting things were pointed out about health care that are almost unique to this industry. One of the more interesting is that most hospitals and many nursing homes in both our state and nationally are pretty big businesses but many are not-for-profits and most of them are community-based organizations.”

“This means that they were originally organized around a mission that did not specifically include the idea of making money. We all know that we have to be profitable in order to continue to pay bills and buy

“The fact that these ‘boutique’ operations usually don’t have to staff for second and third shift and weekends and holidays allows them to attract many health care professionals without paying a premium for their services. Since about the 1930’s, physicians could earn far more (as much as 100 times more) for doing procedures than using cognitive skills. Consequently, ‘procedure intense organizations’ are always going to have higher profits.”

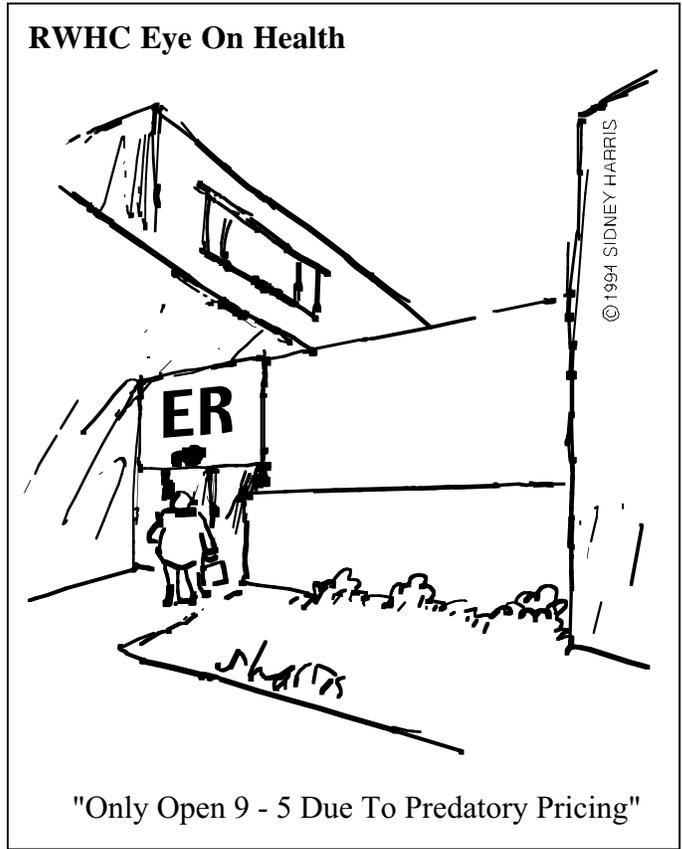
“The problem with these organizations is not that they exist. It is not even that many are taking advantage of their not-for-profit status to build big reserves (although that is somewhat troublesome.) The real issue for me is that they are so specialized that they are not serving the large medical needs of their communities, yet Medicare and many insurance companies are using their operating cost as a marker when determining what they will pay full service community hospitals for the same procedures.”

“Truly community health care organizations are opened 24/7 and take all comers regardless of diagnosis OR ability to pay. We have to staff for low cen-

sus periods because we can't schedule medical emergencies. And because we don't know what is going to come to our door step, we have to stock our emergency rooms and pharmacies for as many eventualities as practical. We have to pay physicians, nurses, lab techs, x-ray techs, etc. to be on site or on call to be available when the community members need us. We can't schedule medical emergencies, but we have to always be prepared to respond."

"Surgery and other free standing centers and specialized hospitals appear to be a truly competitive health care delivery model that in the long run may endanger our communities' overall access to health care."

"I tend to be a believer in free markets- and I don't fault someone for finding a way of doing something as well or better and at a lower cost- but eventually we may have to put some types of controls on the proliferation of these types of organizations if we want to preserve the diagnostic and treatment capabilities that our communities expect general hospitals to maintain."



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