Rural Wisconsin Hospital Cooperative

Executive Director's Report

as of September 15th, 1994

A monthly report of experiences and observations to RWHC hospitals & colleagues.

AHA, CHA, VHA & W. K. Kellogg

The American Hospital Association's Hospital Research and Educational Trust (HRET) in collaboration with the Catholic Hospital Association and VHA, Inc. through funding from the W. K. Kellogg Foundation is hosting an invitational *Community Benefit Summit: Pathways to a Community Care Network Vision* on September 29th and 30th in Chicago. Prairie du Chien, Viroqua and RWHC have been invited given our participation in AHA's Community Health Intervention Partnership initiative, one of the antecedents of the *Community Benefit Summit*.

"The summit is the first major activity of the National Demonstration of the Community Care Network Vision: Focus on Accountability. The W. K. Kellogg Foundation has awarded a $6 million grant to HRET to help the vision of community care networks become a reality. Kellogg's grant will support the development of 20 sites of fully-operational community care networks. Coalitions of health and community organizations will compete for 20 grants worth up to $300,000 each by proposing on-going ways to improve their communities' health. HRET will release a request for applications in the fall of 1994, and by March 1995, the sites will be chosen. The sites will be selected from across the country, with at least seven rural sites designated.

NRHA Distributes Reform Promotion

While Congress is almost certain to be dropping the ball on reform, the debate in Washington (and Wisconsin) is not over; those of us who care about rural health need to continue to put forth our vision or be left behind when legislative movement finally occurs. In an effort to remind both the public and Congress that national reform should help rural health (or at least do no harm), the National Rural Health Association will be shortly mailing "camera ready copy" for member use in their local newspapers. All that is needed is for you to select the advertisement size you want, add your logo and send it down to the local paper. The four principles expected to be emphasized are:

- Universal access and coverage
- Limiting Medicare/Medicaid cuts
- Training more primary care providers

- Funding for rural health care infrastructure

All NRHA and RWHC members are encouraged to make use of these promotional materials as well as to again communicate with members of their Congressional delegation during these last days of the current session.

Rural Medical Centers Moving Again

After a certain loss of momentum, Wisconsin's public private partnership to reinvent the way we regulate and describe rural health services is back on track. An in-depth and fresh look at the entire RMC initiative by Larry Hartzke, the new project director, set the stage for an unusually productive meeting of the RMC Steering Committee. Direction was given to amending the draft statutory language now working its way through the administration as well as further specifying tasks to be accomplished within the department.

For the first time, it was noted that while the Essential Access Community Hospital Program's had not taken the nation by storm and was not a silver bullet for all rural health issues, PCHs (primary care hospitals) may prove to be an approach needed by some rural communities, particularly those wishing to radically down scale inpatient services while maintaining an Emergency Room.

It was agreed that this issue would be brought up at the next meeting of the WHA Rural Health Committee. If the Committee supported moving forward, an effort would be made to amend the draft RMC statute by adding a reference to the federal PCH in the proposed statutory list of defined services.

As the Steering Committee works with staff to further refine what RMCs are and are not, there was agreement re the following "design specifications" detailed by Larry:

- Needs to provide two or more of the defined services (hospital care, nursing home care, home health services, hospice care, rural health clinic services, outpatient rehabilitation services, ambulatory surgery center services, ESRD services.)

- Is not limited to any particular type of medical provider.

- Will generally be subject to standards with the same level of rigor as comparable single-service providers.

- Is not intended to be a franchise in a given area, i.e. there conceivably could be several RMCs in a community.

- With one exception, RMC-defined services are limited to (but include all) those for which DHSS conducts either licensure or certification surveys.

- Does not require geographic contiguousness of RMC services at a single site (this differs from the original draft of statute.)

- Is not required by DHSS to provide a "core" set of medical services.

- Licenses would be valid for a two-year period.

- Consolidated surveys would be performed once every two years (assuming federal approval.)

"Specialist Glut, Generalist Shortage"

Yesterday's Washington Post had an excellent article by Wisconsin's David A. Kindig; a few excerpts are noted below:

"The health care reform debate has raised an issue that will not go away even if comprehensive reform falters or is delayed: What is the role of government in the financing and control of graduate medical education? Most of the reform bills considered by Congress proposed limiting the number of physicians trained and specifying the balance between generalists and specialists - in return for public funding of training costs."

"Critics of this approach argue that governmental interventions are not necessary and that market forces will lead to needed adjustments. Further, they argue that teaching hospitals should continue to receive federal subsidies without accountability for the number and type of physicians produced. The Council on Graduate Medical Education, the body established by Congress to advise on this issue, disagrees. So do most other public advisory and professional organizations in the field. Why is governmental intervention needed? Why will market forces fail to correct these imbalances?"

"First, although the growth in managed care and the demand for primary care has nudged generalists' income upward, this has had little impact on specialty choice. Many students interested in primary care but saddled with high educational debt still opt for specialties."

"Second, the health care market does not determine what type of specialists are trained. Teaching hospitals do. Those hospitals find trainees are cheap labor for providing specialty services. Furthermore, Medicare generously pays hospitals for any trainee recruited even if trainees are not needed once they complete training. The disconnect between the teaching hospital "market" and the medical practice "market" contributes to, rather than corrects, the specialist glut and the generalist shortage."

"It is common sense that if precious public dollars are being used to train doctors, then government should make sure that we pay for the doctors that are needed."

TV Special: "Spirit of Cooperation"

From the Wisconsin Federation of Cooperatives: "The story of how cooperatives have helped America and how they will continue to meet people's needs into the 21st century will soon be told on public television stations across the nation. 'The Spirit of Cooperation,' narrated by actor James Earl Jones, will be aired October 10th at 10:00 p.m. by the following Wisconsin public stations: WHA, Madison; WHWC, Menomonie; WPNE, Green Bay; WHLA, LaCrosse; WHRM, Wausau; and WLEF, Park Falls. Among the cooperatives featured are CENEX, the Associated Press, Sunkist Growers and Nationwide Mutual Insurance Company.

Medicaid Managed Care To Expand?

A number of providers and HMO representatives met at the invitation of the Wisconsin Department of Health and Social Services to share our impression re the wisdom of expanding the Medicaid program's use of managed care. This meeting was consistent with an increased consideration nationally of expanding Medicaid and Medicare HMO enrollment in order to lower costs and improve quality of care.

While not discussed by DHSS representatives, all state departments have been asked to present three budgets: a 0% change, a 5% cut and a 10% cut as part of a process to identify alternatives to fund the billion dollar property relief bill. A 10% cut in the Medicaid program would means a total loss of $250 million in the combined state and federal spending to achieve a $100 million saving in state funds.

While the invited attendees were supportive of the idea of expanding the current use of HMO's by the Medicaid program the state representatives were understandably hesitant. While a number of observations are relevant, the following reasons for a go-slow-approach were among the points discussed:

- The marginal benefit to the state of expanding the AFDC Medicaid initiative will be less than that current achieved in the Milwaukee area. Having started in a densely populated, high cost market, the state achieved relatively high cost savings with relatively low administrative overhead. However, the remaining AFDC population is in lower cost markets that are also more expensive to administer.

- 70% of the Medicaid budget is spent for the benefit of 55,000 enrollees; many of these recipients are disabled. Improved program efficiency may require a different model of managed care than that currently used for the AFDC group in Milwaukee or commonly available elsewhere.

AHEC Retreat: Changing Assumptions

This year's Wisconsin Area Health Education Center System Retreat takes as its theme, Dialogue For The Future: Changing Our Assumptions. The keynote address will be by Dr. Patricia McManus on "Issues of Cultural Competence in Health Professions Education." A panel on "Meeting Wisconsin's Needs for Primary Care Physicians" bring together a diverse set of medical leaders: Michael Bolger (President, MCOW), Ron Franks (Dean, UW Minnesota School of Medicine-Duluth) and Larry Marton (Dean, UW-Madison).

Rural Action Without Urban Control?

To paraphrase a friend, even thick skin can be punctured with a well aimed dart. Until last week, it had been almost fifteen years since anyone has directly questioned my independence from Madison and my loyalty to the Cooperative. Beyond the unwelcomed personal slur, the comment was evidence of a more common and more serious problem–what I call urban myopia–a belief that the Cooperative or any other rural organization should not or can not take independent action. Tough business and policy discussions degenerating to the level of personal innuendoes and a patronizing attitude towards rural providers may be an unavoidable consequence of the brave new world of mega-system development and competition, but I certainly hope we in Wisconsin can do better.

Aurora, RWHC Break Bread Together

The problem with learning to march to an urban tune, is that you keep looking for a more powerful and richer deal-just kidding, reread the above item. Before another rumor gets started, I'll disclose that I had breakfast last week in Madison with Kevin Fickenscher, MD, Aurora's new VP for medical affairs or some such title. While it is true that I'll eat with almost anyone, Kevin and I are old friends through our work with the National Rural Health Association.