

The Rural Agenda For Healthcare Reform

For rural providers, some of the most important provisions in healthcare reform proposals currently being discussed are those which would build the capacity for delivering services in rural areas. Unfortunately, according to Jeffrey Human, director of the Federal Office of Rural Health Policy in Rockville, MD, many of these provisions are not likely to survive the congressional battle ahead.

ON- VERSUS OFF-BUDGET PROVISIONS

In most healthcare reform proposals, Human explained at the National Rural Health Association's annual conference last May, provisions that would benefit rural areas are on budget rather than off budget. Provisions that are *off* budget—such as increases in payments through taxes, through Medicare, or through employer payments—are self-financing and thus perhaps not subject to the same scrutiny as on-budget items, he explained. But, he noted, these off-budget provisions are “intended to extend coverage to a larger part of the public, but not to extend capacity into rural areas.”

In contrast, rural capacity-building provisions are generally on budget. These provisions include expanding the National Health Service Corps; putting more money into community health centers; supporting the development of rural networks; and providing tax incentives for physicians, physician assistants, or nurse midwives to settle in rural underserved areas. Because they are on budget, Human explained, “they are subject to a budget agreement between the president and the Congress not to increase domestic spending over the next few years. For every dollar Congress decides to appropriate to increase the training of advance practice nurses, for example, a dollar has to be subtracted somewhere else. And the presidency and Congress in recent years have had a hard time cutting or eliminating existing programs. Therefore it's going to be very hard to add these capacity-building proposals.”



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LIKELY AREAS OF SUCCESS

Although Human predicted a long-term struggle for rural providers to obtain the capacity building they need, he added that some reform provisions benefiting rural healthcare providers are likely to succeed:

- Most healthcare reform proposals currently under debate include transition protection for some providers in health profession shortage areas—that is, transitional “safety net” payments to ensure that rural healthcare providers receive fair and adequate payments during the transition to universal coverage. However, automatic designation for such protection may be limited to government-certified or government-funded clinics.

- Graduate medical education reform—such as a tax on insurance premiums to finance residency training for physicians; and control of residency slots to ensure that 55 percent of all residents go into family medicine, pediatrics, obstetric medicine, or internal medicine—is likely to pass. “We will be graduating the kinds of physicians we need in rural areas,” Human said, “although it’s unclear that those physicians will be settling in rural areas in any greater numbers than they do now.”

Slowing of the rate of Medicare growth and cutbacks in Medicaid also seems likely, Human predicted. However, Andrew Coburn pointed out that another important question is whether the Medicare beneficiary population will be folded into mainstream health plans. Coburn, an associate professor for research programs and health policy and management at the University of Southern Maine, Portland, also serves on a panel of experts recently assembled by the Rural Policy Research Institute (RuPRI) to advise Congress on rural health policy. Coburn noted that the panel believes including Medicare beneficiaries in mainstream health plans is “an important step in ensuring stable reimbursement and hopefully improving the financial status of rural providers.”

THE IMPORTANCE OF LOCAL CONTROL

Another significant issue for rural providers is how to maintain local control of the delivery system, stated another RuPRI panel member, Wayne W. Myers, MD, professor of pediatrics and director of the University of Kentucky Center for Rural Health, Hazard. Myers noted that reform proposals to invest in urban academic medical centers in order to improve healthcare in rural areas are "a classic case of investing in the fox to go take care of the henhouse."

For example, RuPRI's March 1994 publication, *The Rural Perspective on National Health Reform Legislation*, points out that many current proposals to increase funding for graduate medi-

cal education build on our current system, which is controlled by large, urban teaching hospitals, rather than specifically targeting programs to training for rural and underserved areas. RuPRI recommends instead greater distribution of training opportunities and national planning based on population to give local communities more assurance of having their needs met.

Human further warned against "the Walmart syndrome," named after the large chains that move into small communities with great fanfare about new jobs and economic benefit, but end up putting local companies out of business and supplying only low-paying jobs. He said that an

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CHARACTERISTICS OF A RURAL INTEGRATED DELIVERY NETWORK

Many aspects of the debate on healthcare reform and provider integration have centered on urban and suburban settings, yet in rural areas change is also occurring rapidly. Throughout Kansas, for example, rural communities are developing integrated systems for delivering healthcare, reported Steve McDowell, president of Rural Health Consultants, Inc., Lawrence, KS.

In studying 12 rural Kansas counties as part of a project funded by the Kansas Health Foundation, McDowell said that he and his colleagues discovered the following characteristics essential for successful integration of healthcare services in rural areas.

The System Should Be Built on Essential Services Identified by the Local Community The community has to take ownership of the project, to assess what it is realistic for them to provide and what is not, and to set the appropriate level and set of services for its circumstances, McDowell noted. For example, obstetrics and surgical services may not be in the cards. Although there is no "cookbook of components," he said the scope of services for a rural community might include emergency medical services, routine health maintenance, preventive care, care for acute conditions, prenatal care, basic diagnostic services, short-term inpatient services, a continuum of long-term services, and essential local public health services.

Decisions Should Be Conceptually Framed by the

Epidemiology of the Market Decisions about the level and set of services to offer must be based on data on the community's demography and epidemiology. McDowell noted that communities with a history of data-based decision making are more likely to develop integrated delivery networks.

The Size of the Rural Market Should Determine Whether the System Is Population or Service Area Based Managed care requires a large population—as large as 800,000 according to one study several years ago, McDowell reported, though current estimates are more like 60,000. Thus a smaller community may be subsumed under a larger, urban-based system, and several competing health plans in an area may be more concerned about the needs of all their members (the majority of whom will live elsewhere) than in the community as a whole. In some small communities, McDowell said, a locally developed system that serves the entire service area may be more accountable and likely to address the spectrum of healthcare needs.

An Accountable Single Entity Should Manage Resources and Assume Risk In some communities, where six to eight providers are still in competition, they must work toward forming a single entity, McDowell asserted, to be able to deal with "urban predators" down the road. In Kansas, for example, managed care networks in two big cities "are coming out after rural folks to get more covered lives and to

cover bad debt," McDowell said. He warned that although these large companies may make tempting offers to area businesses in order to cover their employees, they often end up closing

hospitals or making other decisions not in the community's best interest.

Outcome Measures Should Be Community Oriented Rather Than Disease Based The measures of the appropriateness and effectiveness of the delivery of care should not be based on the diagnosis-related groups making money, but on the effects on the health of the entire community.

Prevention and Early Intervention Are Essential Components of the System An effective rural integrated delivery network must go beyond the medical model to emphasize wellness-based care and maintaining access to a full continuum of services.

Advanced Levels of Care Should Be Provided through Networking with External Sources The diagnosis and treatment of many problems (such as cardiac or orthopedic surgery) are better addressed in a facility with a large patient base, McDowell said, so an integrated rural delivery system must identify and establish a formal referral system with an urban facility, often using telecommunications to facilitate transfers.



McDowell

important aspect of localized control and financing is for the managed care product and insurance company to be based in the community.

"If your insurance company is based in the city and your premium dollars go there," Human said, "you know that some percentage less than 100 will eventually return to the community." So he advocates "managed care systems in rural areas where you pay the money locally, the money stays locally, and care is delivered locally, and you're making an investment in the viability of the community as well."

MAKING THE RURAL VOICE HEARD

At press time, the healthcare debate seemed as if it might stretch indefinitely into the future. But even if it were settled this year, rural providers would still have some years of struggle ahead to achieve their own goals.

One problem, Human pointed out, is that none of the current proposals includes requirements for rural representation on any of the advisory or decision-making boards. If such representation were required, he said, "at least we could keep our foot in the door no matter what happens and have a place where we can have a voice in what's happening."

RuPRI panelist J. Patrick Hart, PhD, noted that the organization has been in contact with Congress to try to influence legislation. But he added that the target is moving so fast, it is hard to keep up with. "I have a sense that the rural voice has gotten very low and quiet," Hart said. "Part of it is because we have various constituencies in rural America and we're often not comfortable about stepping on other people's toes." But, he added, in the current unstructured situation, rural providers have greater opportunity for having an effect on the outcome. "We've got to get rural back on the agenda," Hart said.

—Susan K. Hume

Rinset stressed the importance of a clearly defined decision process.

ANXIETIES OF RESTRUCTURING

Despite these efforts, anxieties persist, Rinset said, in part because organization restructuring will continue to entail work-force reductions. The top-level management structure is already in place, but Providence General's midlevel restructuring, which is just getting under way, will eliminate many of its 100-plus managerial positions.

Rinset stressed the importance of a clearly defined decision process as organizations go through such changes. To develop a new organizational chart, Providence General assigned task forces to determine how to reorganize the organization's functional areas (e.g., nursing services). A central group, the merger task force, coordinates the efforts to ensure that none of the smaller task forces operates in a vacuum.

"As we have worked through this process," Rinset said, "people have become more assured that it is a fair and effective way to make decisions. They know the process and have seen it work. Some have given feedback to help design it, and some have been members of the task forces that make recommendations."

EXCITEMENT OF CHANGE

Despite the inevitable difficulties related to the merger, Rinset said excitement is growing within the organization as people realize they have an opportunity to create a dynamic new organization that better serves the Everett community. "In my experience, the level of cooperation between the community, the medical staff, our institution, and the system is unique," he noted. "I have been constantly impressed by how solidly the board has backed our efforts and how well they have understood their role and the role of management."

One sign of the board's growing

awareness of its new role was a decision to disband its community relations committee, which had focused on public relations and advertising, and replace it with a community benefit committee. "The new committee's role," said Chairperson Hayes, "is to learn what the community needs and to look for ways to help bring that into being."

A more tangible benefit of the merger has been the elimination of the magnetic resonance imager on the Colby campus, which will save Providence General about \$600,000 a year. The organization is also talking with a Lutheran skilled nursing facility in town, which had been planning to spend \$15 million to replace an aging physical plant that no longer met state standards. The two organizations are discussing the possibility of relocating the facility to one of the PGMC campuses.

Rinset noted that the new arrangement would not only produce a "dollar benefit" but a "care benefit" as well because it would simplify the movement of patients within the healthcare delivery system. Another step PGMC is taking to simplify access to care is to merge the insurance contract at the organization's two campuses. The move will allow patients to use a service at either site if it is available there.

LIVING WITH CHANGE

"People frequently ask me when the changes are going to stop," Rinset said, "and I tell them that they are not. We're simply going to have to get better at handling them."

"Not everyone is going to be happy with the changes," he continued. "So as you move forward, you just keep working on improving attitudes and increasing the number of people who are cooperative, supportive, and committed." □