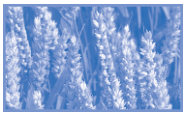
Kansas Rural Health Policy Agenda




2003

Kansas Rural Health Options Project




Kansas Rural Health Options Policy Agenda Committee

Charles T. Allred, M.D.
Smoky Hill Family Practice, Salina

Keith Bailey
United Methodist Mexican-American Ministries, Garden City

Virgil Bourne
Atchison Hospital, Atchison

Jo Ann Doan, M.S.N., B.S.N., R.N.
Fort Hays State University, Hays

John Dudte, M.P.A., MICT I/C
Emergency Services Education, Wichita State University, Wichita

Kenneth L. Duensing, D.O.
Kansas Osteopathic Association, Blue Rapids

Elaine Johannes
Research and Extension Office of Community Health, Manhattan

Sheri Floyd, P.A.
Kansas Academy of Physician Assistants, Ozawkie

Rick Gray
Area Mental Health Center, Garden City

Leonard Hernandez
Holton Community Hospital, Holton

Mary Beth Hermann
Pawnee County Health Department, Larned

John Lehman
Apostolic Christian Home, Sabetha

Lori Litton
St. Catherine Hospital Home Care Service, Garden City

Jan Moffitt
Marion County Health Department, Marion

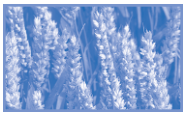
Charlotte Peake, A.R.N.P.
Republic County Family Physicians, Belleville

Jodi Schmidt
Hays Medical Center, Hays

Lorene Valentine
University of Kansas Medical Center, Wichita

The Kansas Rural Health Options Project (KRHOP) is a partnership among the Office of Local and Rural Health (Kansas Department of Health and Environment), the Kansas Hospital Association, the Kansas Medical Society, and the Kansas Board of Emergency Medical Services. KRHOP is funded by a grant from the federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services. This document was prepared by the Kansas Health Institute. Copies are available by contacting Tom Sipe of the Kansas Hospital Association at (785) 276-3116 or tsipe@kha-net.org.



RURAL HEALTH POLICY AGENDA
Kansas Rural Health Options Project

All but nine of Kansas' 105 counties are classified as rural by the federal government. Residents of rural areas are older, sicker, and poorer than their urban counterparts. They are more likely to be injured or killed in an industrial accident or a highway mishap. Despite their need for more health services per capita than urban areas, many rural areas experience shortages of health professionals and health care services. The health care system in many rural areas plays multiple roles. It is not merely a provider of health services, but the first or second largest employer in the county, the meeting place for civic enterprises, and a key variable in economic development along with the quality of schools and local taxation policy. The rural health care system is not simply the urban health care system in miniature. The problems caused by low service volumes, limited human and capital resources, travel distances between patients and providers, and rural demographics are unique. The solutions to these problems are also unique to rural areas.

The Kansas Rural Health Options Project (KRHOP), a collaborative of the Office of Local and Rural Health (Kansas Department of Health and Environment), Kansas Hospital Association, Kansas Board of Emergency Medical Services, and Kansas Medical Society, assembled a task force of rural health providers and educators to identify the most important rural health issues in rural Kansas and to suggest reasonable solutions that could be implemented. The task force concentrated on five issue areas:

- Access to health services
- Quality of care
- Health work force
- Financing health services
- Public health and emergency preparedness

Federal policy deeply affects rural health in Kansas. Medicare payment policies and health service delivery regulations have the largest impact of any public policies on providers of health service. Medicaid is a shared federal and state responsibility. Although the authority for many decisions about the Medicaid program resides in the statehouse, these decisions must be made within the framework of federal law. Federal policy influences the availability of physicians in underserved areas, some of which are rural, through a number of programs. And finally, the danger posed by bioterrorism creates new responsibilities for public health agencies and health care providers. Some health policies developed in Washington, D.C., have unintended consequences when implemented in Washington County, Kansas. They fail to take into consideration the size of some rural communities and the unequal distribution of resources.

KEY ISSUES IN KANSAS' RURAL HEALTH

Access to health services

- Low volume and changing rural demographics require health care systems and rural communities to adapt to meet the needs of their residents.
- The supply and availability of physicians in some rural areas is inadequate, and the entire rural primary care system is fragile.

Quality of health services

- Federal quality standards do not recognize the measurement and resource issues related to quality assessment in rural areas.
- Many rural areas lack the human and financial resources to fully implement quality management programs.

Rural work force

- The shortage of registered nurses and allied health professionals has had a disproportionate impact on rural areas.

Financing of rural health services

- Medicare and Medicaid prospective payment systems do not properly recognize the cost structure and behavior of low-volume providers and consequently underpay them.
- The burden of uncompensated care due to uninsurance and under-insurance is large and growing in rural areas.

Public health and emergency preparedness

- Local emergency medical services systems are inadequately funded to respond to large-scale emergencies.
- Many small local health departments possess limited resources to deal with either routine operations or large-scale emergencies.

Access to health services in rural areas has three important dimensions: availability, affordability, and acceptability.

Some of the issues identified in this agenda are not unique to rural areas, but they affect rural areas disproportionately or require a different policy solution. Solutions to these problems are not to be found solely in the actions of state and federal lawmakers. While they play an important role in addressing many of the concerns listed here, we call on county and municipal officials, rural communities, universities and colleges, philanthropies, and rural providers themselves to join legislators in promoting favorable changes in rural health.

ACCESS TO HEALTH SERVICES

Access to health services in rural areas has three important dimensions: availability, affordability, and acceptability. Because of the sparse population of many rural areas, some services — such as those of medical specialists — that might be available in an urban area are not offered in rural areas. There simply is not enough volume within reasonable travel times to make some services profitable for a potential health care professional. Consequently, local access to most specialty services and virtually all sub-specialty services are denied to most rural Kansans.

The lack of health insurance coverage or the excessive burden of cost sharing for people with insurance may cause some to forgo needed care. Uninsured and under-insured people may view health services as unaffordable, and they may not consume services except in dire emergencies. (The issue of the uninsured and under-insured is discussed more fully in the section on health care financing.)

Services are acceptable to rural residents, if they are adequate to satisfy a need or a requirement. Acceptance is affected by knowledge, beliefs, and the culture of caregivers and patients. When knowledge of the range of locally available services is incomplete, residents believe that the service is not available. In other words, they believe the local health care system does not satisfy their needs. Incorrect assumptions about the quality of services provided by rural health care practitioners make some rural residents seek out urban providers. Finally, services are acceptable only if they are culturally competent. Culturally competent providers attempt to deliver services to patients in ways that recognize, respect, and accommodate differences in language, cultural values, concepts of time, and spiritual and religious beliefs.

Issue: Low Volume and Changing Rural Demographics

The population of many rural areas — especially in western Kansas — is shrinking. On average, rural counties in Kansas have lost population in every census year since 1930. The remaining population is older and poorer, on average, than urban populations in Kansas. One area of population growth is among racial and ethnic minorities. Minorities in Kansas comprise 17 percent of the population, up from just 12 percent in 1990. The proportion of Hispanic/Latino residents of the state increased by 101 percent between 1990 and 2000. The population density of minorities in some rural counties is high. The 2000 Census reports, for example, that more than half of the population of Seward County is composed of racial and ethnic minorities.

These changes in demographics mean that health care systems in rural communities will have to adapt to meet the needs of their residents. Communities will need to offer more community-based and

behavioral services to allow the elderly to age in place. The availability of culturally competent health care will have to expand to serve minority residents. The smaller volume of services due to shrinking populations will force communities to decide which services they can afford to continue offering.

Options:

- Support community planning efforts aimed at deciding the mix of health services that are needed by the community and assessing the ability of the community to support and sustain those services.
- Support development of marketing plans and tools that enable rural providers to more effectively promote the range and quality of services offered locally.
- Develop Medicare and Medicaid payment systems and programs that provide for community-based chronic care and preventive services.

Issue: Supply and Availability of Rural Physicians

The small number of physicians serving rural communities and the high turnover among them make the rural medical delivery system extremely fragile. The decision of one physician to leave a rural community has a much larger impact than the turnover of one physician in a more densely populated area. For example, in a rural area served by three physicians, the loss of a single doctor would reduce the availability of medical resources by one-third and require each remaining physician to increase his or her patient load by 50 percent. Some rural communities in Kansas are served by only one physician.

Access to certain services in rural areas is limited by the supply of physicians. For example, if a general surgeon is not available to provide services in the local community, no surgeries will be performed despite the presence of a fully equipped operating room in the local hospital. Because of federal programs like the National Health Service Corps and the J-1 Visa Program, most rural communities have access to primary care services locally or within a short drive. Access issues typically focus on medical specialists.

The line between primary care and some common specialties, such as obstetrics/gynecology, pediatrics, and some internal medicine subspecialties, is not always clear. For example, a family physician may deliver a baby or treat children. When patient volumes are low, primary care physicians and specialists compete for patients. This competitive environment can hamper the ability of communities to recruit and retain certain specialists.

Another barrier to access in rural areas is that some providers do not accept Medicaid patients because they believe the payment rates are too low. Some providers do not accept insurance assignment from any third-party payers and require patients to pay in full at the time of service and file their insurance claims themselves to seek reimbursement. This payment policy may limit access because some patients do not have the resources to pay the full amount of their medical bills.

Options:

- Encourage the federal government to maintain its investment in the National Health Services Corps and continue the J-1 Visa program.
- Improve rural physician reimbursement, especially for Medicare and Medicaid.
- Require all physicians and dentists licensed in Kansas to accept

Medicaid payments.
- Maintain the state's investment in the Kansas Medical Student Loan program and the Kansas Bridging Plan.

QUALITY OF HEALTH SERVICES

Two standards of quality, one for urban providers and one for rural providers, do not and should not exist. All health care providers should strive to deliver the highest quality possible consistent with their scope of services. Many rural providers, however, have difficulty measuring and reporting the quality of services they provide.

The current emphasis in quality measurement is to assess the outcomes of care — is the person better or worse off because of the care delivered? Outcomes are defined as unambiguous events such as a death and are expressed as the relationship between the number of people who received a treatment (or who had a diseases) and the number who died after receiving the treatment. For example, the nosocomial (or hospital-acquired) infection rate measures the ratio of hospital-acquired infections to admissions at a specific hospital. Because of the low number of cases in rural areas (the denominator), the measurement of the quality of outcomes and processes in rural areas is frequently meaningless at best and misleading at worst. These incorrect measures may overstate or understate the quality of services delivered and rarely identify true problem areas correctly.

Issue: Inappropriate Quality Standards

Licensed institutional providers such as hospitals, nursing facilities, and home health agencies are surveyed using federal quality standards and guidelines developed for the Medicare and Medicaid programs. These performance standards measure the presence of an appropriate quality measurement system. For a number of years, hospitals and other health service providers have moved from retrospective quality assurance (QA) to continuous quality improvement (CQI), which emphasizes perpetual, real-time study and improvement of the process of health service delivery. Despite the improvement of CQI over QA, the federal standards still emphasize QA. Retrospective measurement of events and the problem of small numbers make an accurate assessment of the quality of care provided in rural areas difficult.

Options:

- Develop quality management systems that recognize the quality measurement problems of low-volume, rural providers.
- Develop federal standards that stress quality improvement over quality assurance.
- Encourage greater interaction between state surveyors (inspectors) and rural providers to improve surveyors understanding of rural quality issues.

Issue: Limited Quality Management Resources

Many rural providers lack the human and financial resources to fully implement quality management programs. In small rural health organizations, staff members are asked to wear multiple hats. Difficulty implementing quality management systems is often a matter of having too little time, too few people to carry it out, too little training in quality improvement, or a combination of the three. Although national training programs exist, generally they are expensive, offered in distant cities, and do not focus on the needs of rural providers. Due to the small number of physicians in some rural areas, rural physicians may be forced to use urban physicians for

peer review. Rural physicians frequently have a smaller menu of diagnostics and therapies to draw on than urban physicians. Insensitivity to the scope of medical resources available to rural physicians can influence perceptions of the care they provide.

Options:

- Provide training and technical assistance on quality measurement and improvement to rural providers. The training should be:
  - Offered at low or no cost to providers
  - Repeated routinely to reinforce learning and accommodate staff turnover
  - Offered in sites that are easily accessible to rural providers
  - Provided for various provider types (for example, physicians, various hospital departments, skilled nursing facilities)
- Encourage networks of rural providers to work together to address quality of care issues cooperatively.

RURAL HEALTH WORK FORCE

Nurses and nurse aides, technicians and technologists, physicians and dentists, and a variety of other health professionals are in short supply throughout the health care system of Kansas. Whenever there are health care work force shortages, rural areas are particularly hard hit. Medicare policies that pay rural providers less than urban providers for the same services inhibit the ability of rural providers to compete for employees in large regional labor markets. Even if money for higher wages were not an issue, many rural areas would have trouble recruiting and retaining health professionals because of isolation, limited employment opportunities for spouses, and urban lifestyle bias. For some health professions, the current labor shortage is different than previous ones. Due to changes in the economy, demographics, and social norms, it is expected to be widespread, long-term, and acute.

Issue: Recruitment and Retention of Nurses and Allied Health Professionals

In sheer numbers, the shortage of nurses is by far the largest health work force issue confronting the state, but it is not the most acute shortage. Hospitals are the largest employers of most health professionals. The Kansas Hospital Association reported that staff nurse vacancies totaled 358 in January 2002, for a vacancy rate of 7.8 percent. In contrast, the vacancy rate for entry-level social service workers was 13.6 percent, but the actual number of vacancies was 13. Long-term care certified nurse assistants, licensed practical nurses, diagnostic imaging technologists, respiratory therapists, laboratory technicians, and others are all in short supply in rural areas. Because emergency medical technicians in rural areas serve largely on a voluntary basis, the issue of EMT staffing shortages is chronic.

Options:

- Develop health careers scholarship programs targeted to rural applicants. (A wealth of research collected over 30 years indicates that health professionals who grew up in rural areas and who select rural areas as their first practice site tend to remain in rural areas for the bulk of their careers.)
- Encourage state universities, colleges, and community colleges to increase their capacity to train health professionals. The number of instructors, classroom space, and clinical experience sites currently limits state capacity.
- Examine creative ways to use the education system to offer training and degrees to rural and non-traditional students.
- Promote rural economic development to help provide employment

Even if money for higher wages were not an issue, many rural areas would have trouble recruiting and retaining health professionals.

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opportunities for spouses of health services workers.
- Allow intermediate certification during nursing education that allows student nurses to perform activities they are trained to carry out.
- Limit health professional certification and licensing to occupations that have a clear need for state regulation. (Creation of barriers to practice may limit the supply of allied health professionals.)

Issue: Fewer Kansans Choosing Health Careers

Female workers historically have tended to predominate in the health professions. In recent years, however, the number of women selecting health careers has declined for two reasons. The perceived attractiveness of health professions relative to other jobs has declined, and alternative opportunities for potential health care workers have grown. Job expectations among younger workers have also changed. They expect better work conditions, more flexible hours of staffing, and greater pay than previous health professionals. Unable to satisfy these expectations in health careers, some opt for other training opportunities or leave the health professions prematurely. Because many high school students are not well prepared in the biological sciences, they do not develop an interest in health careers. Men and minorities are under-represented in the health professions relative to their proportion in the population. If they were recruited to health careers in larger numbers, they would create a work force that better reflects the gender and ethnic/racial composition of patients, in addition to helping alleviate the work force shortage. These factors combine to create a smaller pool of health care workers to replace the aging work force and to satisfy the demand for additional workers due to increases in population and medical technology.

Options:

- Encourage men and racial and ethnic minorities to enter health professions that traditionally have been filled by white women.
- Implement work place reforms that address changing job expectations, such as flexible staffing, greater professional autonomy, and career ladders.
- Promote health careers and bioscience education in elementary and secondary schools.

FINANCING RURAL HEALTH SERVICES

The low volume of services provided in many rural areas creates special financial problems for rural providers. When the volume of services provided is below the break-even point for a practitioner or facility, it is unprofitable to continue to offer the services. Raising the prices of services is not an effective alternative because few patients pay the actual prices set by providers. To continue to offer an unprofitable service requires a provider to cross-subsidize the service with a profitable service, obtain non-operating income from gifts or local taxes or use accumulated equity until it is exhausted.

Low volumes also produce higher average costs. The cost of goods and services is comprised of variable costs and fixed costs. For the most part, fixed costs do not change with the number of goods and services produced and are distributed evenly over the number of units produced. When fewer units are produced, fixed costs per unit are higher. The higher contribution of fixed costs at low volumes means that the cost of many services produced in rural areas are higher than those produced at higher volumes. Rural providers attempt to deal with this situation with cost-saving strategies such as offering lower wages and benefits,

streamlining staffing, and closing unprofitable services.

Issue: Government Payment Systems are Inappropriate for Low-volume Providers

Beginning in 1984 with Medicare payments for inpatient hospital services and expanding over time to Medicaid and a variety of other health care providers, governments have implemented prospective payment systems. Under prospective payment, a fixed payment rate is set, based upon the average cost at an average facility. If a provider can deliver the service at less cost than the fixed payment, the provider can keep the difference. If it costs a provider more to deliver the service than the payment, however, the provider must absorb the loss. Intended to create incentives for provider cost reduction, prospective payment works well in theory at large volumes where profitable and unprofitable services balance each other out. Because many low-volume providers have volumes whose costs are above payment rates, they lose money on most services. When outliers occur — patients who require more care or care at greater cost — losses grow even deeper. In addition, Medicare adjusts its payment rates geographically, paying rural facilities and individual practitioners less than it pays their urban peers.

Option:

- Redesign Medicare and Medicaid payment systems to properly recognize the cost structure and behavior of rural providers.

Issue: Uncompensated Care

"Uncompensated care" is service delivered for which a provider receives no compensation. In accounting terms, it is the sum of charity care and bad debts, although many rural providers do not even track uncompensated care. Hospitals that received Hill-Burton construction grants and National Health Service Corps clinicians are required by federal law to treat patients without regard to their ability to pay. The mission statements of many hospitals promote the provision of charity care. Many rural providers also follow this rule, but some do not accept patients who are uninsured or cannot afford to pay for services out-of-pocket. Some do not accept Medicaid patients because they believe the payment rate is too low. Although it has not yet become a problem in Kansas, national reports document that physicians in other states have begun to opt out of the Medicare program because of low payment rates. When some providers restrict services to patients on the ability to pay or the source of payment, these patients tend to cluster disproportionately in practices and facilities that do accept them.

Most uncompensated care is delivered to people who do not have public or private health insurance. Rural populations tend to have lower rates of insurance than urban areas. Many small employers, who are the major employers in rural areas, cannot afford the cost of health insurance and do not offer it to their employees. Rural areas also have a higher proportion of self-employed individuals who cannot afford the cost of premiums in the individual insurance market. Another source of uncompensated care is "under-insurance," which occurs when patients are unable to pay their cost-sharing obligation (deductible and co-insurance). Services for patients without health insurance and who meet provider-determined criteria for indigence are considered charity care. Care for a patient who is under-insured

or for a self-pay patient who cannot afford to pay the entire bill is considered a bad debt.

Payments by Medicare and Medicaid to most rural providers are less than the amount the providers charge for their services. The difference between the amount paid and the amount charged is called the "contractual allowance." Because Medicare and Medicaid payments do not keep pace with medical inflation and changes in the health care product due to technology and patient demand, the ratio of contractual allowances to charges grows larger every year.

Options:

- Improve systems to enroll people who are eligible for public health insurance programs, but who have not applied for them.
- Improve access to the small group insurance market:
  - Low-premium expansions of public insurance programs to cover the working poor
  - Insurance risk-pooling for small employers
- Encourage employers who hire foreign workers to help assure adequate health care for them.
- Eliminate unnecessary complexity and intentional delays in insurer payment systems to speed payments to rural providers and reduce their investment in accounts receivable.
- Provide tax incentives to small employers who offer health insurance to their employees.

PUBLIC HEALTH AND EMERGENCY PREPAREDNESS

The threat of bioterrorism that emerged after the events of September 11, 2001, placed new emphasis on public health and the systems of care that support emergency preparedness. After decades of neglect, federal money is now being made available to improve public health infrastructure so that local health departments can respond to a biological or chemical attack. As one federal official said recently, "It takes a system that is competent to handle routine public health situations to handle the emergencies."

The rural emergency medical service (EMS) system is extremely fragile. It relies largely on volunteers to operate it. Training volunteers to assure their ability to respond in emergencies is a constant challenge, as is staff turnover and scheduling. Local EMS systems are owned and operated by a variety of public and private organizations throughout the state. The equipment and supplies used vary widely. Although in Kansas, EMS systems are regulated and supported by the Board of Emergency Medical Services, at the federal level, EMS has no "policy home." Federal concern for EMS floats between the Department of Health and Human Services and the Department of Transportation. In the billions of dollars allocated to the fight against bioterrorism, not a single cent has been earmarked especially for EMS development, an odd omission given the importance of medical transportation and pre-hospital treatment in an emergency.

Issue: Under funding of EMS for Emergency Preparedness

Rural EMS systems are rarely profitable. Like firefighters, EMS professionals largely stand by, waiting until they are called upon to provide critical life-saving services in unforeseen, sometimes dangerous, moments. The number of calls they receive in any given year are small, especially compared to urban providers. Although much of the standby costs of EMS are reduced by the use of volunteers, the cost of ambulances and the equipment used

in them represent a substantial capital investment. Only a fraction of the true cost of providing EMS services in rural areas is ever recovered.

While bioterrorism is the primary threat for which the health care systems of Kansas are preparing to respond, it is not the only threat for which emergency preparedness is warranted. Weather emergencies, train, plane, and multiple car wrecks, and industrial accidents are some of the emergencies that will require pre-hospital treatment and medical transportation. To date, EMS systems have not been well integrated into emergency preparedness planning at the local level.

Options:

- Promote bioterrorism preparedness funding for EMS system improvements.
- Concentrate federal EMS policymaking in a single agency, preferably the Department of Health and Human Services.
- Encourage organizations and agencies that deal with emergency preparedness planning to integrate EMS more fully into their efforts.
- Encourage state universities, colleges, and community colleges to maintain their EMS professional training programs.

Issue: Limited Public Health Capacity in Small Local Health Departments

There are 99 local health departments in Kansas, almost one for each county. Public health is one of the basic services of local government. Like the sheriff or the fire department, public health officials help protect the public and ensure their safety. While the sheriff and the fire department deal with threats of violence and fire, public health professionals deal with lowering the risk of communicable and environmental disease. Because public health is not well understood — and because when it works well, it is invisible to the public — it has not received much attention in recent years. Many small local health departments lack the needed infrastructure to do their jobs effectively. The public health infrastructure means the capacity and competence of the work force, information and data systems, and local health department organizational capacity, as measured by performance standards.

Options:

- Encourage development of cooperative networks among local health departments to share services and leverage scarce resources.
- Involve county commissioners in public health planning to a greater degree.
- Build incentives into state funding of local health departments that encourage greater cooperation and regionalization of services.
- Encourage and assist public health workers to obtain additional training in public health.

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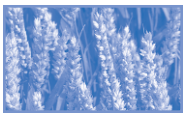

Produced by

Kansas Health Institute

212 S.W. Eighth Avenue

Suite 300

Topeka, KS 66603-3936

KANSAS HEALTH INSTITUTE

for

Kansas Rural Health Options Project

215 S.E. Eighth Avenue

P.O. Box 2308

Topeka, KS 66603-2308

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