Wyoming Healthcare Commission Meeting Minutes

Monday, Feb. 28, 2005

Hathaway Building , Cheyenne , WY

Attendance: T. Chris Muirhead, Chairman, Steve Mossbrook, Vice Chairman, Marlene Ethier, Jack Glode, M.D., Carol Jenkins, Paul Lang, Jack Speight, John Vandel, Commissioners, Deborah Fleming, Ph.D., Wyoming Department of Health Director and Ken Vines, Wyoming Insurance Commissioner, Ex-Officio Commissioners, Anne Ladd, Director, Emily Genoff, Assistant Director, and Jan Kruse, Project Coordinator.

Meeting called to order at 8:15 a.m. by Chairman Muirhead

Chairman Muirhead introduced Bev Morrow, Division on Aging administrator, invited to present the needs of the aging in Wyoming , and the implications of a growing elderly population for healthcare delivery (handout, "Morrow").

Ms. Morrow reported that Wyoming was once predicted to be the oldest state in the nation in 2020, but the minerals boom has made the state younger. Now, Wyoming is anticipated to be the fifth oldest state in the nation in 15 years, according to a recent AARP (American Association of Retired Persons) study. Between 1990 and 2000, Wyoming saw an increase of 22.2 percent in its population 65 and older, compared with a 12 percent increase for the nation's 65-plus population. Education levels are lower in Wyoming than nationally. Women earn less in this state than in others. Wyoming 's suicide rate is the highest in the nation, and elders are among those committing suicide. Forty-five percent of Wyoming citizens older than 65 have a disability. Most older people have at least one chronic condition and many have multiple conditions. Half of all people age 85 or older have Alzheimer's or other dementia disorders.

According to Ms. Morrow, disabled adults have to be considered with the elderly in the continuum of care offered by the Wyoming Department of Health's Division on Aging. Some people need long term care for a period of time and then need less support, and economic resources bear on the types of services provided. Community services benefit people who have lower levels of dependency and impinge little on their autonomy. General categories of services offered are: information and referral, senior center services, volunteer programs for retired seniors, older workers programs, and disease prevention and health promotion.

Ms. Morrow detailed the programs offered by the Division to assist people at all levels of need, which in include meals, shopping assistance, companion visits, assistance with insurance and Medicare, transportation, legal services, help transitioning out of nursing homes back into communities (Project Out), in-home services for people at risk of institutionalization living in poverty, adult day care, and long-term and assisted living

facility Medicaid waivers. These programs enable to people to stay in and keep their homes, independence and sense of control over their lives.

The Olmstead decision by the U.S. Supreme Court requires Americans with disabilities and who are aged be assisted in the least restrictive environment possible. Transportation is a big issue in Wyoming . Not every community has a bus available; getting people to services is a necessary part of assuring they are able to live outside of institutions. A problem for people transitioning out of nursing homes is affordable, available, handicap-accessible housing. There are only 100 slots available in the state for the assisted living Medicaid waiver. An attempt to add 25 slots is being considered in the Legislature. People who spend a significant amount of time in hospitals and rehabilitative care may be pushed into particular settings by funding streams.

Wyoming only has about an 81 percent nursing home occupancy rate, Ms. Morrow said. Project Out also assists people who are 45 to 60 years old and disabled put in nursing homes who are more suited for other settings socially and mentally. Work is being done to build transition cost payment into Medicaid, because deinstitutionalization saves money. Discussion followed regarding opportunities to assist family caregivers (Vermont allows for payment to family members that stay with an Alzheimer's sufferer rather than institutionalizing that person, for example) and assisted living facilities options in Wyoming , based on funding.

The only publicly subsidized assisted living facilities in Wyoming are in Thermopolis (Pioneer Home) and Buffalo (Veterans Home), Dr. Fleming said. Neither is full but private programs complain when the state advertises them and people don't want to relocate, preferring facilities in their own towns to moving, according to Ms. Morrow. Under Wyoming law, waiver-enrolled people cannot be placed in state assisted living facilities. There is a waiting list for the Assisted Living Facility Waiver. Long term and assisted living waivers provide care at about half of what nursing home care can cost.

How many people are going to need services and at what level is being considered but insufficient data exists to determine when more facilities should be built, in light of the fact the demand is expected to increase. Life expectancy continues to rise; women outlive men, according to the discussion and Ms. Morrow.

Discussion followed regarding end of life preparation being part of some Division on Aging programs. Coordination between agencies is getting some attention – but more work needs to be done. On the Medicare Advantage program, there are requirements for end of life plans. There is a bill in the state Legislature on advanced healthcare decisions that has been more controversial than anticipated. Education is needed, for physicians and families faced with making or helping with end of life decisions.

Workforce shortages are impacting elderly care, since the workforce is aging and the number of young people available and interested in healthcare professions are falling short of demand, Ms. Morrow said.

The Commission was introduced to Catherine Sreckovich and Candace Williamson of Navigant Consulting, presenting the draft Rural Healthcare Study overview. The study was commissioned by WHCC to look at the system of delivery of services in the state and potential other, adaptable models.

The study's foundation was health professional shortage and service distribution benchmarks based on definitions of urban, rural and frontier areas. It was determined that not every service could be available to every person in every location so core services were identified, on the basis of being high demand, time sensitive, and time intensive: primary care, obstetrical care, mental health and substance abuse, emergency transportation, dental, home health, inpatient hospital, nursing facility care and pharmacy services. This is where we start seeing some issues in counting providers, their specialties and delivery areas when fitting them into benchmarks, Ms. Sreckovich said.

Healthcare access doesn't encompass just geographic location and capacity of providers but also the economic standing of patients and whether providers will accept those who are uninsured or public programs (Medicaid, Medicare, worker's comp). No attempt was made to measure economic access, although anecdotal information was obtained as part of the study. "That's not something we were able to address in this study," Ms. Sreckovich said.

The data available was a matter of continuous debate in the study, she said. She reviewed the sources of information used in the study and the gaps – such as whether providers are part or full time, how many patients are leaving the state for care if they have private insurance, and whether people from other towns are coming to Wyoming for care. It was impractical to project a decade or more into the future regarding the availability of physicians. Information resulting from the study, then, is to be taken at face value, she said, although there was some projection done in conjunction with the study regarding nursing home care needs in Wyoming

Commissioner Vandel said there is a need for a legislative mandate for the reporting of professionals based on licensing information. Ms. Sreckovich said healthcare provider capacity guidelines were developed for the study. Communities were categorized into six population size-based divisions. Distance guidelines were established for core services in each category. Other states' work was used as a basis for choosing benchmarks. North Carolina and Oregon used ranges for nursing home care that were considered bases for Wyoming 's, in the study recommendations, she said.

Based on geographic analysis, in most towns there is access to providers within the travel guidelines established. About 10 percent of the population does not have geographic access to ob/gyn services. Other areas with core services lacking tend to be small – about 95 percent of the population has geographic access to care, Ms. Sreckovich said. Navigant didn't try to make a projection about the need for a provider in a town where there is no provider now. Whatever the state does, obviously a lot of input is needed from people in communities who understand access issues and travel patterns – things that cannot be extracted from a database.

Where capacity is concerned, primary care, ob/gyn, psychiatric and dental care are coming up short, Ms. Sreckovich said. Mid-levels (physician assistants, nurse practitioners) and out of state providers are not considered, however. Navigant's health professional shortage area data had findings similar to the U.S. Health and Human Services Health Resources Services Administration's Shortage Designation Branch data for Wyoming . About 70 percent of the Navigant shortage area classifications made by Navigant compared to Medicare's shortage data, as well, she said. Discussion followed regarding which data provides the most current and useable information and the shortages of each source.

Out of state hospitalizations accounted for 16 percent of Wyoming residents' hospitalizations – mostly for cardiac, orthopedic and nervous system disorders. Colorado was most frequently used, Utah was number two and Montana was number three. Discussion followed regarding the number of dollars leaving the state for care, how many of them are tax dollars and whether that is appropriate, and whether leakage can be controlled. Navigant's work shows right now only 3 percent of Medicaid patients are leaving the state for primary care.

Navigant will propose in its final report a new community project for Wyoming incorporating multi-county regions, a center for services in a convenient geographic location or in a population center, and provision of services via satellite offices and outreach to more remote areas. The "hub and spoke" model allows for development of primary care resources on a local basis, development of specialty and other institutional services on a regional basis, and patients receive primary care services in or near their communities, while specialty care services are provided in the hubs, Ms. Sreckovich said.

Integrated rural healthcare networks use the resources of more than one existing organization and specifies the objectives and methods by which various collaborative functions will be achieved and shares administrative and management functions, as well as potentially reducing costs through shared purchasing arrangements and shared service usage. Hub and spoke delivery models help attract specialists to hubs, where there is sufficient population to support their services, allocate resources efficiently while providing access to primary health services in remote areas that cannot support a full-time provider and reduce professional and clinical isolation through encouraging collaboration and improved communication among providers. However, hub and poke delivery models provide no mechanism for the government to force redistribution of existing private providers, require counties that may not have a history of working together to coordinate and consolidate their resources and may intensify tensions between rural and urban providers, Ms. Sreckovich said.

Discussion followed regarding how to facilitate location of healthcare provider centers, through health policy or construction of state-owned, centralized clinics. "In time, the counties are going to get out of the healthcare business," Dr. Glode predicted, as the economics of it become increasingly difficult. "Our job is to envision the model," Chairman Muirhead said. All communities need to have a role in deciding what's needed,

Bob Kidd, Wyoming Hospital Association President, said. There needs to be a planning function but steerage of state resources forcing particular services in and out of communities will result in rebellion, he predicted. Incentives through reimbursement are a better bet. "A super czar state planning function has been tried in this state and failed," Mr. Kidd said.

Facilitation of community input through regional boards helps capture the importance of the personal nature of health care and the importance of coordination of input to a statewide board, Ms. Sreckovich said. An example is the trauma care regions already in existence in the state. Regional boards would be responsible for assisting in determining local needs and the environment and the collection of data, making sure all the data is up to date. Prioritization has to happen so there is not a lot of duplication and overlap, to make the most of federal grants and other resources.

Iris Oleske, State Medicaid Agent, was asked to answer questions from the Commission about out-migration of patients whose care is funded with tax dollars. Federal law prohibits patients from leaving the state. No more than about 10 percent of the entire Medicaid budget goes for patients out of state. Most of that goes for intensive needs – births and transplants. Medicaid does pay for patient travel. Patients have to have the option of choice. "All of our hospitals have provider-specific rates, if they have enough history in providing that service for us to establish that rate for them," Ms. Oleske said. "On the basis of cost coverage, the larger the hospital the less likely we are to cover all of their costs. All in-state hospitals, we are covering about 86 percent of cost coverage for inpatient." Outpatient cost coverage is less than 50 percent, however.

Discussion followed regarding the variation in reimbursement for different Wyoming hospitals and the opportunities patients have to go out of state. Periodic "rebasing" allows Medicaid to pay a portion of all costs, but no one is overpaid, Ms. Oleske said. What about the opportunity to send patients to specific hospitals based on the outcomes that hospital has for certain types of procedures? Commissioners asked. Ms. Oleske said to some extent, physicians are steering the patients in that way. Other states, particularly where there is competition, are using "report cards" to determine what hospitals are better at certain procedures. Mr. Kidd said nationally, report cards are going to become routine. Benefits of educating patients and payers about outcomes measures were debated, then, by commissioners. Cost is a much more important driver than quality at this point in time, Dr. Glode said. "My bias is that we work this through payer, rather than through the educated consumer, at this point in time." Experience shows consumers use other information than data to make decisions about where to get their care, he said.

Ms. Sreckovich said other states' rural healthcare initiatives include non-emergency transportation systems to provide access to healthcare for rural residents without transportation (Texas, Washington, North Dakota), mobile services to provide healthcare services to remote areas (Vermont, Texas, Virginia and California), partnerships between state and insurance companies to deliver dental services to kids (Michigan), and telemedicine and related technology to improve access (Wyoming and most other states have restrictive licensees that prevent sharing across borders for specialty services).

Other states are capitalizing on the telemedicine market, requiring third-party payment for telemedicine, providing limited telemedicine licenses to allow physicians who whole unrestricted licenses in their home states to practice across state borders (Alabama, Montana, Nevada, Oregon, Tennessee and Texas). Recruiting and retention of healthcare professionals is a popular means of improving healthcare access and Wyoming is working along those lines through WWAMI, locum tenens coverage, grant and scholarship programs for nursing students, Ms. Sreckovich said.

Strategies for developing and implementing initiatives to address healthcare needs were outlined by Navigant to focus attention on certain activities likely to benefit the state, including centralized databases tracking professionals delivering health services in the state and the type of care needed and by whom, she said. "Concierge" or "boutique" medicine was discussed by the commissioners, and the potential for changing the way services are delivered to make what is provided more patient friendly than school buses or even shuttles. Wyoming isn't a competitive market, however, so there is not the pressure to resort to more extreme measures to attract patients.

The final rural health study report will be done March 7 and will be mailed all commissioners. A telephone call on March 14 at 5 p.m. will allow for review of any comments. On March 21, the Commission will consider release of the report to the public at its regularly scheduled meeting, in Casper .

A model state health professional database example was presented to the Commission by Koleen Kohll, RN, Director, Health Profession Tracking Center , Nebraska Provider Tracking Center (handout, " Nebraska "). Nebraska 's project was launched with Robert Wood Johnson seed money. Nebraska captures knowledge in a comprehensive relational database that is unique, with "unmatched data integrity" and a GIS interface. The inventory started with physicians in 1995 but now includes physician assistants, nurse practitioners, dentists (including Wyoming 's), pharmacists, pharmacies, clinics, acute care centers and hospitals. Western Iowa is included due to its proximity to Omaha , in order to capture what healthcare patterns were unfolding.

The directory is comprehensive – without "boundaries" – to encompass providers who are not practicing but are still licensed and federal professionals who are not licensed locally. Diligent persistence in collecting information is required, including a survey (85 percent to 100 percent compliance), licensure comparisons, a clipping service, telephone verifications, "good will" notifications and internet research – all necessary to assure that information is current and accurate regarding who is working where, and when. The Center does nothing for health professional data tracking and has a staff dedicated to that.

Data is sold to help support the Center, but only selectively. Data collection is written into grants. No information is provided to drug companies, but they haven't asked for any – they're looking for nationwide data, Ms. Kohll said. Directories, however, are sold to local pharmaceutical reps. It's a medical phone book sold for $65 apiece and institutions order them in gross. Patients routinely call for information about specific providers'

“special specialties,” ethnicity and languages, to assure the best possible match of patients and providers in some cases. The Center provides information affecting 45 state and federal programs, including community health center and rural health center eligibility, eligibility for grant assistance, J-1 Visa applications, and Medicaid and Medicare cost-based reimbursement. A family practice shortage area comparison provided a 50 percent increase in the HPSA designations and more than $1 million in improved CMS reimbursement, and prevented indirect medical education budget cuts, Ms. Kohll said.

As of Feb. 14, there were 3,200 physicians practicing in the state and 10 percent practice in a rural area. Ms. Kohll detailed the information she could harvest from the database they maintain in Nebraska , and the value of the data. Twenty two states have contacted Nebraska , interested in duplication of the program and database. Wyoming ’s chances of replicating what Nebraska has are good. “I think your state is very doable. I think this is something we could get up and running very quickly,” she said. There is a letter of intent through the Robert Wood Johnson deadline April 1 that would be a good start if Wyoming wants to do something like this, she advised. She volunteered to help – she had already targeted Wyoming has an expansion or partner state -- and has a connection with Robert Wood Johnson already. She would request $275,000 to finalize data element priorities, determine associated costs, develop surveys and cover letters and establish a single data repository and incorporate current data. But Ms. Kohll said she needs more information about what the WHCC needs before she can develop a proposal.

“This is one of the items we enumerated to the Joint Appropriations Committee we would do is a true database with information deeper than the names of providers and their addresses. What are the possible funding issues?” Chairman Muirhead asked. Wyoming Department of Health State Office of Rural Health (SORH) manager Lynne Weidel said she has mandates for data collection and has no money to do this kind of research. They have some grant money they could contribute. They also want to have input. “I think it’s important that those of us using the data will have input in what is collected,” she said. Vice Chairman Mossbrook pointed out that the SORH would be a customer.

A representative of Wyoming Health Resources Network (WHRN) said that organization is in the process of inventorying physicians (full and part time), nurse practitioners, and physician assistants, whether they are participating in loan repayment, whether they are in WICHE or WWAMI, and a head count of nurses. Comparisons are being made with previous data. Their intent is to work toward what Nebraska has become. It took five years for Nebraska to be self supporting. However, the Center remains under the University of Nebraska umbrella. Discussion followed regarding working with the Nebraska program and collaborating with entities in Wyoming already aiming toward similar, albeit piecemeal, data collection efforts.

Meeting adjourned for tour of Wyoming Department of Health pathology laboratory.

Next meeting: March 21, Casper .