



THIS NEWSLETTER IS A PUBLICATION OF THE

Texas Association of Rural Health Clinics Quality Health Care for Rural Texas

Meltdown – It's the Stupid Economy

2009

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The majority of the information for this particular RHC newsletter item is taken from an article by Ian Morrison who is a consultant and futurist based in Menlo Park, California. He is a regular contributor to Hospitals & Health Networks (H&HN) Weekly www.healthforum.com

The recent market meltdown is fundamentally reshaping the planet. World markets are shaken and American families have lost trillions in net worth as home values tumble, as retirement accounts plunge and as unemployment and job insecurity rise. Yet, health care seems like a safe haven to some of the investment experts. However, in Mr. Morrison's view, health care will not remain unscathed by the recent economic collapse. Here are a few of his observations on the long-term effects of the market meltdown.

Reduction in ability to pay – the current economic crisis is being felt by business, government and households alike, severely constraining their ability to pay for health care. The payer's ability to pay is constrained in any recession, but in an environment of high government deficits, high household debt, shrinking corporate profits and tight credit markets, the problems with the ability to pay are aggravated considerably.

Pitting out of pocket healthcare costs against other household budget items – as consumer purchasing power gets eroded, the rising co-pays and deductibles that patients face become even more onerous, leading to patients forgoing treatment and visits.

Anecdotal evidence shows slowing consumer demand for prescription drugs, routine office visits and elective procedures. *Searching for the value menu* – in an economic slowdown we move to the value menu at McDonalds, but in health care we have few options. With the exception of Wal-Mart's \$4 generics, there are not that many value choices in health care. Patients simply don't get the care, or they cut their medications in half or postpone the checkup or procedure.

Supplier-induced demand – at the same time consumers cut back, providers need to make

up the shortfall. The classic health economics view of supplier-induced demand might rear its ugly head as providers try to promote more activity among the better insured and more affluent patients. Revenue cycle enhancement can become a cover for up-coding as well as for unnecessary tests and procedures for the affluent.

Rising number of uninsured and underinsured – unemployment and rising "unaffordable" care raise the number of uninsured, and those employers who want to provide health benefits often stay in the game by increasing cost-sharing. As the number of uninsured and underinsured swell, providers will face increased costs of uncompensated care.

Rising cost of capital and credit – health care is a huge employer and has a big payroll to meet. At the same time, providers face enormous capital budgets for new construction, expensive clinical technology and electronic health records. The market melt-down is causing dramatic short-term spikes in the cost of credit, which foreshadow a longer-term challenge with the rising costs of capital.

Effects on recession on government – recession typically hits hardest at state budget coffers. With limited ability to run deficits, states face the double whammy of increased Medicaid and welfare rolls as revenues decline. Since states' finances typically lag behind a broader recovery, the budget hole could be deep and long, putting huge pressure in state and local government-funded safety nets for years to come.

Effect of the bailout on future spending – the federal government bailout, the wars in Iraq and Afghanistan, and the huge number of budget priorities at the federal level may have sucked all the available oxygen out of substantial health reform. The ability of the federal government to cover the growing ranks of uninsured will be limited by close to a trillion dollars tied up in economic recovery plans. No matter how popular or pressing, any large scale-health care reform proposals may have to be tailored to an austere time and may have to be phased in, postponed or piecemealed to accommodate the economic realities.

NARHC 2009 Spring Institute

It is time to start making your plans to attend the **National Association of Rural Health Clinics (NARHC) 2009 Spring Institute** being held in San Antonio, Texas, at the Hyatt Regency Hotel on 123 Losoya Street (right on the Riverwalk near the Alamo) on **Sunday, March 8, to Tuesday, March 10, 2009.**

Here are highlights of the conference:

Sunday, March 8 - Pre-Conference - 9:00 am to 5:00 pm

- ▶ History of RHCs
- ▶ Billing 101
- ▶ Cost Reporting 101
- ▶ Coding & Documentation
- ▶ The In and Out of Re-Inspections
- ▶ ICD 10 Information

A networking reception will be held from 5:30pm to 6:00pm

Monday, March 9 - 8:00 am to 5:30 pm

- ▶ Legislative Update
- ▶ Rural Health Clinic Cost Reporting
- ▶ CMS Update
- ▶ Breakout sessions:
 - ▶ - How to start a State Association
 - ▶ - Embezzlement/Fraud- Are you willing to gamble your practice?
- ▶ Rural Health Clinic Accreditation Process
- ▶ Billing issues with MAC representatives
- ▶ Ask the Expert

Tuesday, March 10 - 8:00 am to 12:00 pm

- ▶ Workforce Recruitment and Projections
- ▶ Contracting with Managed Care
- ▶ Access to Pharmacy Programs

On-line registration is available at the www.narhc.org website. Go to the Events Tab and scroll down to the **NARHC Spring Institute** for further information. Hotel reservations must be made by **February 15th** to (800-233-1234) receive the conference discounted rate of \$159 a night plus tax. TARHC members pay the same conference registration fees as the NARHC members. Please contact the NARHC Administrative Services Office at 866-306-1961 with any questions.

CMS Rural Health Open Door Forum

The **Centers for Medicare & Medicaid Services (CMS)** has its next **Rural Health Open Door Forum (ODF)** scheduled for Wednesday, January 28, 2009, from 11:30 am to 12:30 pm Eastern Time (10:30 am to 11:30 am Central Time).

This **Open Door Forum** is being held in conjunction with the National Rural Health Association's Rural Health Policy Institute annual meeting in Washington, D.C. Here is the **call-in information if you wish to join in on the conference call: Toll free 1-800-837-1935 Conference ID 70013728.**

The **Rural Health ODF** addresses Rural Health Clinics (RHC), Community Access Hospital (CAH), and Federally Qualified Health Center (FQHC) issues, as well as some inclusion of other questions and concerns that occur in the clinic practice pertaining to other CMS payment systems that also extend into these settings.

TrailBlazer Average Processing Days for CMS-855 Applications

In an effort to keep providers informed of current enrollment process timeliness, TrailBlazer periodically shares current average processing days on all initial enrollment, change of information and reassignments (for Part B only). Current enrollment data as of January 8, 2009 is:

Part A average Days to Process – initial application 158 days; changes of information 81 days

Part B average Days to Process – initial application 81 days; changes of information 95 days, and reassignments 69 days

Public Health Television: Advancing Positive Health and Social Outcomes

This article by Thomas N. Longbotham, MA, is his research from attendance at NARHC meetings in San Antonio and St. Louis during 2008 with the principals who want to bring this free public television aspect to all RHCs in Texas and the United States. TARHC has been in communication with the chief operating officer of this organization to offer this service to Texas RHCs when it is implemented. The physical location for this nationwide web-based public health communications service will be in Austin.

Rural Health Clinics stand as evidence that communities can improve health, reduce health disparities, and deal with a multitude of costly and significant health and social problems – including substance abuse, HIV/AIDS, mental illness, and homelessness – if they have the resources to do so. *Public Health Communications, LLC (PHC)* is dedicated to the goal of using **Public Health Television** in informing underserved populations about available services and important health issues, such as preventative health care. The rural health community is usually last in getting these types of opportunities. Now there is a rare chance where we get the first opportunity.

Public Health Television provides for an infinitely scalable

(Continued from page 2)

system with a robust functionality for programming and delivering content. Unlimited options for directing information to displays based on hours of operation, display location, time of day, viewer demographic, preferred language, etc. Content can be uniquely targeted to every screen in the network individually. The content will be vetted from reliable government, academic, and medical organizations. The digital signage screen can be used for self promotion of the clinic as well as state and national RHC associations. Clinics will also be able to use of the signage unit for staff training. For a preview of the content visit www.CDCTV.com.

IPTV (Internet Protocol Television) is a system where a digital television service is delivered using **Internet Protocol** over a network infrastructure. Changes can be made quickly and cost effectively via internet connectivity; and targeted programming can be distributed to individual displays, hundreds, or even thousands of displays at once. The screens are programmed with adjustable digital real estate—zones for programming distribution and frequency. Zone 1 is an HD quality MPEG4 broadcast quality video

programming with audio. Programming spots are available in 30, 60, 120, and 180 second increments. Each spot is aired one (1) time every 2 hours. Zones 2, 3, and 4 are graphic image (JPEG, GIF) logos or call-to-action. Each 10 second spot will air no less than (6) times every hour. Zone 5 is used for ticker applications such as community information, emergency information, local weather, and a variety of RSS feeds. Each 30 second spot (feed) airs no less than (4) times every hour.

PHC has established long-term *exclusive* Agreements with **the IPTV / digital signage industry's leading technology provider, WireSpring Technologies, Inc.**, and technology integration/deployment firm, **DataStarUSA**. Collectively, these firms possess an unmatched level of experience and industry-leading expertise in the design, deployment and ongoing management of large-scale IPTV/digital signage television networks.

There is a growing market for these services. Funding is sourced from underwriters in a fashion similar to the **Public Broadcasting Service (PBS)** nonprofit model. Government organizations and big industries are gaining greater interest in using digital signage to integrate corporate

responsibility as a core component of business strategy. In 2007, the CDC estimated that \$69 billion is spent funding preventative health messaging (3% of the total health care expenditure in the United States). There were \$597.5 million in total state allocations for Tobacco Prevention Education. The Office of National Drug Control Policy spent \$64.8 million in Community Drug Prevention. The U.S. Army paid out \$68.8 million in High School Dropout Prevention Programs. PhRMA's (Pharmaceutical Research and Manufacturers of America) Partnership for Prescription Assistance Program (PPA) promotional budget was \$48 million.

Public Health Communications, LLC is targeting the underserved population first, focusing on the federal RHC program. Private practices associated with RHCs may be included in the Public Health Television program later down the line. The emphasis is RHCs, FQHCs, Food Banks, and other places within a community that service patients and clients that are less privileged and informed. The company is interested in growing state and national rural health clinic associations through unrestricted grant funds to the individual members that participate in

Public Health Television.

AAASF Accreditation Process Update

The initiative to establish an accreditation process to conduct initial certification surveys and follow-up re-inspections for the rural health clinic program nationwide by a CMS sanctioned organization is beginning to move forward. The American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF) has been invited by CMS to establish a program to certify RHCs, and if approved will offer an alternate to the state health departments being the sole surveyors in the RHC program. AAAASF is currently in the process of developing its program and is scheduling training for anyone who is interested in becoming a surveyor. The National Association of RHCs (NARHC) has requested that anyone who is interested to forward their name and a brief biography of themselves to the NARHC office for consideration. Ideal candidate should be clinical staff such as a physician, physician assistant, nurse practitioner, or registered nurse and they should have a working knowledge of RHCs.

NARHC needs to submit 15 people for consideration to the AAAASF. Travel reimbursement to the meeting regarding the RHC certification accreditation process will be provided by AAAASF. Once candidates are selected and perform a site survey, travel and a per diem will be paid.

For

We have entered the information age:
 Members of TARHC will now begin receiving all newsletters electronically.

further

To make sure we have the current information please give your
 e-mail address: _____
 Also, for our record updates for the Member Directory please
 complete the following and return to us.

Name of Clinic _____

Street Address _____

Mailing Address _____

City _____ State _____ Zip Code _____

Phone (____) _____ Fax (____) _____

Web Site _____

Contact Person _____

Return ASAP to either :
 Fax (512) 873-0046
 Or
 P.O.BOX 14547, Austin, TX 78761

Recruit New Members

The best way to get new clinics to join TARHC is for current members to contact those they know who have not joined and invite them to do so. A membership application is included with the newsletter for you to use.

TEXAS ASSOCIATION OF RURAL HEALTH CLINICS
Membership Application

Regular Membership:

Rural Health Clinic: _____ County: _____

Type of Clinic: Provider-Based: Independent: Certified: Yes No Date Certified: _____

Address: _____ City: _____ Zip: _____

Designated Representative: _____ Title: _____

Phone: _____ Fax: _____ E-mail: _____

If Provider-Based, name of provider: _____

If Independent, indicate clinic ownership: _____



Provisional Membership: (Complete above section) Anticipated Date of Certification: _____



Corporate or Associate Membership:

Individual/Organization Name: _____

Designated Representative: _____ Title: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____ E-mail: _____

Types of Membership: (Check one):

Annual Dues

Regular Membership:

___ Single independent or provider-based certified rural health clinic **\$300**

Provisional Membership:

___ Organization or individual currently in process of establishing/applying for certification as a rural health clinic (eligible for one year) **\$300**

Corporate Membership:

___ Companies doing business with rural health clinics **\$300**

Company Description (25 words or less) _____

Associate Membership:

___ Individual interested in rural health clinic, representative of **\$125**
representative of governmental agency, association, etc.

Make Checks Payable to TARHC and mail to:
Texas Association of Rural Health Clinics

P.O. Box 14547
Austin, Texas 78761

For more information, phone 512-873-0045 or fax 512-873-0046

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Visit www.tarhc.org

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TARHC
Annual Conference
July 28-30, 2009
Austin, Texas

If your administrator/
director, address,
email, phone or fax
number has changed,
please let us know by
emailing us at
torch@torchnet.org.

Remember to share this
newsletter with your
colleagues.