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An Interview With David Peterson and David Jones: Envisioning the Future of Rural Healthcare

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Managed care and other healthcare changes may impact Maine differently than more urban states. Managed care companies, striving to create economies of scale in healthcare financing, often prefer to fold rural regions into larger plans that emanate from more populous hubs. In much of this state, many question whether this will be best for the consumers and providers of rural healthcare.

In December Maine Policy Review staff interviewed David Peterson, president and chief executive officer of The Aroostook Medical Center (TAMC) and Family Practitioner David Jones who practices at Aroostook Family Practice and is an active member of TAMC's medical staff, to obtain their views on rural healthcare and the impact of state and national healthcare trends on rural providers.

Maine Policy Review (MPR): Healthcare is changing a great deal all over the country. Many people are saying that managed care will change Maine in the near future. What is your perspective?

David Peterson (Peterson): There are substantial changes going on in how healthcare is delivered but there are some constants that won't change in the short-term. As rural providers, we have concerns related to accessibility that are driven by geography and a shortage of providers across the whole range of professionals. These problems won't change in a managed care versus fee-for-service or total government program environment. In this regard we will continue to focus on providing accessible, quality care. However, more and more pressure is being applied by the people who pay the bills, or who work for those who pay the bills, to meet the same quality and accessibility standards at a lower cost. Something has to give. In a rural area where the volume of service delivery will never match what it is in more populated, competitive markets, we have some real anxieties about our capabilities to continue providing high quality, accessible healthcare, given growing financial constraints.

David Jones (Jones): Managed care has all of us very frightened. We have real questions about how it will impact our ability to provide high quality care. We don't know how changing finance structures will impact us. We suddenly find ourselves in a new position with managed care creeping in. We spend much more time filling out paperwork and making phone calls to nurse managers who are either downstate or out-of-state in order to perform the routine care that we've always offered. We've had to hire another person in our office just to handle some of the paperwork. We also find ourselves, as primary care physicians, bearing the brunt of educating the public about managed care. We find ourselves having to convey information that should be coming from insurance companies or from the people who change policies. I see some of these issues affecting the retention of physicians in this area. I have partners and friends who talk

about leaving the area; they cite having to work too hard, having to do too much paperwork, and having to worry about financial reimbursement getting impacted even more than it already has. We've had to move toward using more physician extenders and finding new ways to cut costs, even in instances when there aren't many more ways for us to do so.

MPR: To what extent are Maine's hospitals and providers in a position to control what happens in managed care? Is managed care something in which the forces from the larger nation-wide groups--third-parties from out of state--are going to be exerting more control? Do we need to be concerned?

Jones: I have a lot of concerns. We need to worry a great deal about issues of control. In particular, we need to worry about out-of-state people managing in-state rural care and then taking whatever profits are made outside of Maine. With that in mind, a group of physicians and hospitals, myself included, have organized something called Healthnet. Basically, we're forming our own insurance company to initially provide a Preferred Provider Organization and eventually a Health Maintenance Organization for medical care and insurance in this area. This way hospitals and physicians will have more control over both the finances and the quality of care that gets offered. If money is made from Healthnet it will stay in the state, which is very important. The other day one of our specialists expressed a concern that I think is very real. When managed care is controlled from afar, often it becomes a dollar-driven product as opposed to a quality product. When that happens you start looking for the cheapest ways to provide care. Sometimes, the cheapest way to provide care means not offering it in a patient's hometown or home area. For elective procedures we could put people on a bus and send them 200 miles away to have the procedure done. However, if you start taking business away from rural hospitals because you can save dollars by shipping them elsewhere, then you start losing specialists. For example, if we sent all of our elective orthopedic surgery somewhere else where it could be done more cheaply, then we wouldn't have any orthopedic surgeons around for acute care situations like car accidents. We fear that managed care entities from out-of-state will lose sight of patients' needs within the community and lose sight of the fact that sometimes to provide high quality medical care that's available all of the time, it needs to cost a little bit more. So we have many anxieties about managed care from away. We also have some concerns about managed care from close-by.

MPR: Can you say more about Healthnet? How will it affect consumers in rural Maine?

Peterson: It's an opportunity for providers to come together in sufficient numbers to gain some economies of scale and to provide some direction. We opened it up to all of the physicians and hospitals north and east of the Kennebec River and have attracted a large percentage of those people into capitalizing the operation. We have also attracted some attention from the Attorney General's office around the issue of anti-trust. We need to make sure that what we're doing has significantly more benefit to the public welfare than it creates potential problems in the context of restraint of trade. Assistant Attorney General Steve Wessler has an interest for this reason although, for the most part, we've seen a positive interest. Ultimately, I don't think Healthnet will be large enough to create anti-trust issues, but it will be large enough to make a difference in providing high quality, affordable healthcare that has the requisite amount of local control. It's an opportunity. Healthnet will provide a "new" financing mechanism in the hands of familiar

local people--their own healthcare providers. Hopefully, it will display a level of understanding, empathy, and awareness of local and regional concerns not evidenced by the "big insurance companies from away." It can and should, therefore, be more responsive to consumers.

MPR: You mentioned earlier that managed care could result in a decrease in specialty care being provided in rural areas. Can you say a little more? What is the right mix of primary and secondary care providers in rural versus more populated areas of Maine?

Jones: The mix of primary and secondary providers depends on a few different issues. It depends on geographic location; it depends on the size of the hospital; and it depends on history and the expectations of the patient population around that hospital. If you're a rural hospital but you're twenty minutes from a tertiary care hospital, you may not need to touch all the specialties. However, you still may want to do a lot of different things. Many small hospitals that are geographically near one of the big hospitals will argue very strongly that they need to provide a wide range of specialty care. Specialty care helps support primary care, and if patients go to a big hospital for specialty care, they may also see a primary care physician there. Some aspects of specialty care also financially support the infrastructure of smaller hospitals.

On the other hand, The Aroostook Medical Center is 160 miles from Bangor. We're sort of a unique small hospital because of our distance from any of the bigger tertiary care hospitals in Maine. We have to work much harder to provide a wide range of specialty services here because to ask a patient to get in a car or an ambulance and travel three hours to have a specialty exam is a true hardship on the patient. It might represent a cost savings from a managed care perspective, but it's not fair to patients. The further away a rural hospital is from a larger tertiary care hospital, the more it needs to broaden its services. This raises your ratio of specialists to primary care providers. At this hospital, where we serve a wide geographic area, we provide approximately 40 percent primary care and 60 percent specialty care.

Again, my concern is that managed care organizations from away won't fully understand the need for specialty care in our area and will look to fund the cheapest provision of relatively good quality care which may not be the most accessible or the most appropriate. That brings me back to Healthnet. We recognize that there are some expenses, which will be higher than what might be statistically worked out, in maintaining available care in rural areas. We believe that sometimes you have to pay more to maintain services in rural hospitals; otherwise patients are at a disadvantage.

Peterson: I certainly agree with those observations. But in terms of identifying key concerns that we have, we have to be concerned that pure economics could force us in directions we're not really comfortable in going by eliminating some specialty services because of lack of volume. Because of economics, we may have to limit services in rural hospitals and with rural medical staffs. Our feeling at this point is that in the big picture this won't be good for our patients, who deserve the same access to a broad range of services that their more urban counterparts enjoy. Going too far in centralizing services based on economic volumes will limit, and in some cases, deny access. We need to strike a balance.

MPR: One of the issues that is getting a lot of attention in the greater Bangor area has to do with overbedding and hospital downsizing. The demographics suggest there's a substantial overcapacity in this area which has cost implications. It sounds like this issue may not be as pertinent in your area. Can you comment on that?

Peterson: Like other areas in Maine, Aroostook County does have a fairly large overcapacity as measured by licensed beds. I don't translate that into an economic problem. There are not major cost implications associated with our overbedding. We have 83 licensed beds at The Aroostook Medical Center Gould location in Presque Isle. We routinely run a census of about half that total number. We will likely de-license some of those beds that we don't ever expect to use again. But as a practical matter, we only staff for the beds that we're likely to use. If suddenly we had a patient census of 50, we would have a major short-term problem in providing nursing staff. I believe the overbedding, high cost connection is a bit overdone.

MPR: What's your perception of consumer satisfaction in your area?

Peterson: We get a lot of feedback from our patients. We get a lot of feedback from the community. In general, people are very satisfied with the quality and accessibility of care and very dissatisfied with the cost--not relative cost, just plain cost.

Jones: I would echo that, although each one of us has a different experience. I have three partners and two physicians' assistants in my practice, which is very large. Patients are dissatisfied when they can't get in to see the person of their choice. That's a complaint I frequently hear about me. I'm relatively popular and always booked well in advance. Patients complain when they can't get in to see me. It's not that they can't get care in the practice. Their issues with availability have to do with not getting to see the person they want. I would need to be continuously half-booked to be available for those patients who want to see only me and then call expecting an immediate appointment. That's an issue of expectation that probably won't change.

Managed care, on the other hand, argues toward seeing anybody, that what matters in healthcare is timeliness and quality, not who provides it. However, that's an area where I experience my greatest problems with patients. Then, some patients are always unhappy when they have to pay what they view to be exorbitant fees for their medical care. I have a group of patients who are always unhappy with their office charges and a large group who are not. I'm not sure that tension will ever go away--Americans being who they are.

MPR: Maine's mental health system is currently shifting to a governance structure that gives more control to families and communities. What's your perspective on these changes? Are there parallels in the medical healthcare field?

Jones: That's all well and good, but you need a foundation from which to start. If you throw decision-making to the communities but they don't understand how the system works and they don't understand all the costs and outcomes, then you rob them of the ability to make good decisions. They will make decisions based on what they think is good for their community and based on what they think their rights are, but not always ones that are based on a full

understanding of long-term costs and consequences. When you have a limited amount of resources and you have to figure out how to spread them around, it takes an awful lot of planning and understanding, both in the short-term and 20 years from now. I worry sometimes when we unload this stuff onto communities that what we're really doing is avoiding responsibility. This may be good politics; it may be cheaper in the short-term for the state; but in the long-term some of the outcomes may not be what we expected. Some of the costs may be greater and today's decisions will prove to be wrong.

For example, some of the managed care patients that I take care of are now told that a part of good care is their ability to have a free physical every year. As a result, I have patients coming in who think they're taking good care of themselves because they're getting an annual free physical. But they're not taking responsibility for their health in other ways. They think that by coming in and having a physical once a year they will be healthy. There's a huge hole in this picture--a lack of education on the issues. Having a physical every year doesn't mean anything if you're not taking care of yourself and you're not following through with healthcare recommendations. The point here is if you have whole communities making decisions that don't reflect a thorough understanding of the long-term healthcare policy issues then you may not be better off. You may actually be worse and looking for somebody to blame.

Peterson: I'm not comfortable, from the involvement that I've had with the mental health conversion, that the changes are being proposed for the right reasons. We've turned over all of the decision-making to the people using the services and therefore it's not the state's problem anymore. But there's not going to be as much money available. These folks have to decide what to do differently with limited resources. It just has a tinge of state government abdicating a responsibility it has assumed for years.

Philosophically I don't disagree with the disengagement, but it has to be done responsibly. If we were to do the same in the medical care system I think there would be a real potential for major disruptions. Sixty percent of the people we serve have their services paid for by the government through Medicare or Medicaid. If the Medicaid program were simply to walk away and say, "Okay folks, you've got a Medicaid card; you all get together and decide what services you're going to have or not have," that's expecting too much, too soon. We need to have an educated consumer public, but it won't happen overnight.

I do think however, that there is room for local control to deal with certain issues. Dealing with reimbursement restrictions imposed by managed care is an area where local control is needed. We need boards of trustees, made up of local citizens, governing hospitals to provide input regarding how these reimbursement restrictions will or should affect local patient care. There are going to be situations where the best interest of the community is served by doing some things for which we can't get paid. With limited dollars we will have to make some tough choices. For example, currently we provide, in a \$30 million operating budget, a million and a half dollars or so of uncompensated care. It's going to be a real challenge to manage our resources effectively. At times it flies in the face of pure economics. What will be paid for and won't be paid for by the people who are buying services? We're going to rely on community leadership for the common sense approach to answering some of those questions. Hopefully we can then avoid some of the detrimental effects of reimbursement restrictions and other managed care issues.

Jones: To add to David Peterson's answer, there are times when we're going to keep doing certain things here even though it would be cheaper to send patients elsewhere. When we're in a managed care relationship with a group of other hospitals, such as Healthnet, it might be cheaper to send all of our elective orthopedics to Bangor because they have a bigger facility and they do more procedures. They can do it more cost effectively. This hospital won't get reimbursed enough to meet its expenses for doing those procedures. Yet if we send all the elective stuff away, then we lose our orthopedic surgeons in emergency situations. So, there are times when reimbursement will push you to do one thing, when for community benefit, you have to take a loss and figure out how to afford that loss in order to protect your community for medical care in general.

Peterson: In this regard taking the long view may be more expensive in the short run.

Jones: Trying to forget about dollars can be very hard to do.

MPR: It seems like there's greater room for public-private partnerships in how we approach healthcare delivery and healthcare policy.

Peterson: That's correct. Public-private partnerships seem to be developing between payers, providers, and the consumer public outside of the government arena and they will result in a broader perspective than just Maine. This is good because we need to look beyond state lines for some of the answers about how Maine's healthcare system should be organized. One of the points that a number of people have made is that to design a system for Maine that doesn't pay attention to what's happening in the rest of the country is doomed to failure. This is true simply because Maine doesn't exist as an economic island. Too liberal, too costly a healthcare delivery system in one state, like Maine, will discourage business growth since employers bear a large portion of the costs. Too restrictive a system will encourage population out-migration or proliferation of related social problems. An example is our historically very liberal nursing home coverage under Medicaid. To maintain it puts us at a cost disadvantage with many other states. To roll it back creates enormous problems of developing alternatives for populations currently served.

MPR: Looking ahead five to ten years, what's your vision of the future? What would be optimal for you as providers in a rural healthcare setting?

Jones: I could answer that in about ten different ways. I have to start with some givens. Managed care is coming. For me to try and come up with something that doesn't include it would be false. There are a few directions that I would like to see the whole country move in. First, we need to slow down and re-look at managed care and really be careful that the dollar amount isn't the only driving force in determining the care we provide. I also think we need to back up a little and not completely blame the hospitals and physicians for some of the costs of medicine and medical care.

I find that many of my patients are uniquely uninformed about healthcare, about taking care of themselves, about the costs of getting older. I find many people's expectations about such things as care for their elderly mom, dad, or grandmother very inappropriate. We spend a fortune taking

care of elderly people who have terminal illnesses. When you look at some other countries health-care is approached very differently. The money is spent on the young and middle-aged and it's more accepted as you get into your 70s or 80s to die with comfort, but not to die with a \$150,000 bill because you stayed in the intensive care unit for the last months of your life. For a practice of family docs, we provide an intensive level of service. We care for our own cardiac patients. We care for patient illnesses that require intensive care hospitalization. Again, and again, I see younger people expecting that the use of technology and supportive services in-hospital is the appropriate care of elderly people who are dying anyway. We need to rethink elderly care and focus more on home care and accepting that we don't need to use every form of technology on elderly people who are dying just so that the children can go home and not feel guilty. I'm a little bit cynical here, but I see the negative impacts of our country's priorities. What drives the costs of medicine today are doctors and hospitals yet I have a different view of how to bring these costs down that stems from my experience with an awful lot of patients.

Instead of pushing dollar amounts, I would like to see physicians and other providers have more say in peer review and quality of care issues regarding the appropriate care and lengths of stay for some illnesses. I also think we have to accept higher costs in rural areas instead of always looking for the cheapest ways for patients to get care. Most of all, I think the American public needs to change its expectations about what medicine and medical care can do for them. They have to start taking responsibility. Much of this responsibility gets dumped on physicians by insurance companies and others in areas that go well beyond what we can do. The issues that I'm talking about need to be addressed in public policies. We need to look at where money in medicine has been spent. We need to focus on education. People need to take more responsibility for themselves with proper diet and exercise instead of pushing it onto the medical system. I see this shifting of responsibility over and over again. Somehow I'm seen as at fault for patients' illnesses, and am responsible for making them better, when in reality good education and good public policy would have prevented them from ever coming into my office in the first place.

Peterson: From my point of view as a hospital administrator, I envision a delivery system five or ten years from now that has a bunch of empty hospitals. We need entirely too much care for many of the reasons that Dave [Jones] talked about. We are the most expensive parts of the system. Therefore it makes sense to do everything we can as a society to use the most expensive parts of the system least. However, this will not happen until we provide real incentives for wellness, illness prevention, education, and healthy lifestyles. The real, practical, economic incentives today encourage the use of "sick care" services. Providers are incentivized to use resources in ways we get paid for and we can't afford to shift the resources if nobody is willing to pay for wellness-type services.

My anxiety about changing our delivery system in this way relates to the transition period. If we could magically move ahead ten years to a time where the incentives are on wellness, and people understand their own lifestyle responsibilities and have realistic expectations regarding medical care for the sick and dying, then we would have a tremendously effective healthcare delivery system, both in terms of satisfying people's needs and in doing it in an economically reasonable fashion. However, I don't think the overall cost of healthcare service delivery is going to go down in a real fashion anytime soon. Despite this reality we can do things today to change the pace of its increase. These things might include such activities as cross-training staff to take on

multiple lower-volume responsibilities, moving some services to lower overhead settings, combining services in a single location, and streamlining our management process. Some hospital administrators and employees will be out of work as these changes progress. I suspect we'll find other things for them to do if we design the system correctly.

MPR: How do we do a better job of preventive care? How do we start making prevention more of a centerpiece of our healthcare system?

Peterson: We all have a responsibility. Once again, however, economics raises its ugly head and speaks to that transition stage I just mentioned. If we could get all of the people with the bucks to understand the value of prevention they would say, "Fine, let's spend our health insurance premium money on prevention programs." Many are already saying this. But they can't walk away from the sick care programs they've been buying until the effects of the wellness programming begins to take hold. We face potentially higher costs in the short-term because we will have to continue paying for the same sick care while paying for the programs that are ultimately going to reduce the costs of sick care. Here at the hospital we're making major progress in that regard. The utilization of health services by our own employee group (we're the second largest employer in Aroostook County) has gone down dramatically over the last four or five years as we've instituted wellness programming such as diet-education sessions, smoking cessation programs, ergonomic analyses of the worksite, job-specific physicals, and so forth. These programs have had a positive impact on our workers' compensation costs. We've seen these results replicated by a number of employers. However, there are still some employers who don't want to talk about prevention. They want to know what the cheapest way to buy health insurance is or they want to avoid buying it altogether.

Jones: Ultimately, we need to address these issues when our kids are 3- and 5-years-old, and we need to be talking to their parents. Education needs to begin in the school system rather than in the workplace. It's got to be a goal of society that is reflected in our public policies. This seems to me to be spotty. Some school systems do a lot of health education; others don't because parents disagree with it or because of some religious issue; other school systems don't have the money to do it. Up here in the County we have some school systems and individual schools that do a very good job while others don't. The same can be said for industries. But there's no overall set of policies that are implemented across the board. To capture the gains from preventive care, we need to invest in it now so today's young will capture the benefits of it 40 years from now. This is part of why insurance companies have a hard time putting money in now. They're talking to shareholders about a game 30 or 40 years from now but half of them won't even be in the game then.

Peterson: This past summer with the help of the University of Maine at Presque Isle, we and the other hospitals in the county did a community health assessment. It was a fairly brief overview that was intended to give us a sense of what we needed to work on. We discovered some pretty scary things. I don't remember the numbers off the top of my head, but the number of people who begin smoking as pre-teens or around the age of 13- to 14-years-old was amazingly large. Dave [Jones] could document all of the health problems that stem from that one single activity. The health assessment confirmed in my mind that many of our biggest challenges must be addressed with education and significant efforts to change the cultural fabric that contributes to

behaviors like smoking. Our priorities in this regard will have to change in order to achieve my vision of empty hospital beds five to ten years from now.

MPR: We're heading into another legislative session and there are going to be a series of health policy issues debated. From your perspective, are there some near-term policy issues that rural hospitals and providers need to work together on to advocate for or support particular resolutions?

Jones: I have one concern that probably bounces back to what I said a minute ago about education and public policy. We as primary care providers see capitation of the Medicaid system as an absolute disaster for us time-wise. Suddenly we're going to be responsible for telling Medicaid patients why they can't keep over-using the system. Once again, I fear that we don't do a good job in general of educating people on the best use of medical care, the best use of hospitals, and the best way to take care of themselves. The responsibility of educating consumers on these issues is getting passed on to physicians and hospitals who will have to explain why people can't have certain things or can't do certain things.

Physicians see Medicaid as a charity service that we provide for the community or the state, because it's a significantly underpaid form of care. But now we're going to get stuck in the same place that we have been with one or two of the managed care companies that are already in the state--we're becoming educators and deniers of medical services. I would love to see this issue addressed as public policy as opposed to something that gets pushed either on purpose or inadvertently on healthcare providers. I see prevention and general wellness as society's responsibility, not individual physicians'.

MPR: What kind of impact has tax-and-match had on your hospital and are you comfortable with the resolution that came from the legislature in the last session?

Peterson: I'm comfortable in that we achieved what we needed to ultimately, which is that tax-and-match goes away. Tax-and-match was bad public policy from the start; we allowed it to happen; and it's good public policy to get away from it. It has been a major problem for this hospital and other rural hospitals in Maine since it began. Since the first year (where everybody broke even), we have been paying more tax than we have been getting back. Last year the difference was more than \$1 million. In an area such as ours, with a fairly small population, that million dollar cost has a significant impact on what other things we can do in terms of updating our equipment, making sure that we have the right mix of staff, and ensuring that our staff are adequately compensated. In 1996 we're looking at still paying a tax of around \$.5 million more than we will get back in the match.

I understand the value that tax-and-match had and continues to have for the state's economic picture. If it went away today the state would be in a major crisis. But tax-and-match really loaded up the state's fiscal problems on the backs of sick people. Whether it's federal dollars or state dollars, sick people were carrying that load.

MPR: There have been other state policy changes in healthcare. In addition to the resolution of tax-and-match, the Maine Health Care Finance Commission (MHCFC) was de-commissioned and the Health Care Reform Commission concluded with its recommendations. Any perspectives on either of those two things?

Peterson: Both were positive activities. The de-commissioning of the MHCFC and its final demise in fairly short order is an idea whose time has come. Without debating whether there was a real value in establishing it in the first place, clearly events overtook MHCFC. In short, industry and market forces did a better job of keeping hospital costs down than did regulation as witnessed by situations such as our own, where last year MHCFC regulation would have capped our charges for services at over \$5 million more than we actually charged to cover our costs.

With respect to the Health Care Reform Commission, I was able to participate in some of the workgroups and found the discussions stimulating. However, because of the political surroundings, it was implicitly understood that our discussions weren't going to go anywhere-- that it would be tough sledding to come up with actual legislation given the changed legislature and a new governor. I think the commission did a good job of sifting through a huge amount of information and coming up with realistic projections of what Maine can and cannot afford.

MPR: Despite your concerns, and in the midst of some fairly significant changes which carry a degree of uncertainty, you seem to have a sense of optimism about the directions things are going. Is that a reasonable summary?

Jones: I think you have to be excited about change because to be otherwise would be a dismal way to live life.

Peterson: We know what the parts are. Getting them put together in the right order is the significant challenge. I'm optimistic, because if we don't change, we're destined to get worse, which would be another kind of change. If we only try to maintain what we've done and have been doing all along, then we will go downhill because there are too many factors beyond our control. We have to change and I believe we have the capabilities to change for the better. That's really what makes me optimistic for the future of healthcare in Maine.

David A. Peterson has been the president and CEO of The Aroostook Medical Center (TAMC) in Presque Isle since 1987. Prior to that he served as TAMC's chief financial officer. He serves on numerous state and regional boards including the Maine Hospital Association and the Governing Council of the American Hospital Association's Section for Small or Rural Hospitals.

David D. Jones is a family practitioner with Aroostook Family Practice, Presque Isle, and has served as a member of TAMC's medical staff since 1981. Most recently he was named Maine Family Doctor of the Year by the Maine Academy of Family Physicians.

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