

*Review & Commentary on Health Policy Issues from a Rural Perspective - May 1<sup>st</sup>, 2000*

*RWHC Nurse Excellence Award*

Registered Nurse Kristin Christenson of Stoughton is the recipient of the Rural Wisconsin Health Cooperative's (RWHC) first annual Nurse Excellence Award. Christenson, a clinical staff nurse in the day surgery unit at Stoughton Hospital, was nominated for her 35 years of experience, commitment to patient care excellence and spirit of teamwork. Stoughton Hospital's Senior Nurse Executive, Kristi Hund, nominated Christenson for the award because of her major impact on patient care and nursing practice at the hospital. In addition to her clinical nursing duties, Christenson is involved in the Policy and Procedure Committee, performance improvement activities, development of clinical pathways, and Employee Advisory Committee. She serves as a mentor for nursing students and was the founder of the nursing department fun night, a popular social outlet for nursing staff.

According to Tim Size, RWHC Executive Director, the Nurse Excellence Award was initiated to recognize the high quality of nursing practice provided in hospitals serving rural communities. A nurse in the community hospital setting must be well-educated, well-rounded in clinical practice, and have the ability to respond to a variety of age groups, diagnoses, and patient emergencies. The establishment of this award is public recognition that excellence in nursing practice is a valuable asset to rural communities and the state of Wisconsin.

Christenson is a graduate of Methodist Hospital School of Nursing, Madison. She lives in Stoughton with her husband, Stephen, and has three children, Ann, Laura, and Susan.

*Partners In Agricultural Health*

A Wisconsin project long in the preparation, *Partners In Agricultural Health*, is about to become a reality.

Farmers and agricultural laborers face many barriers in accessing occupational health services that address injury prevention education and preventive health care services. Members of farm households have fewer doctor visits and physical examinations each year and are much less likely to have coverage for doctor visits or preventive health care services. This coupled with recent economic difficulties caused by low market prices for livestock and crops, leaves farmers financially unable to obtain preventive health care.

Agricultural workers who find themselves in the health care system in Wisconsin may encounter health care professionals who lack experience and training to deal with the unique needs of this rural population. Health care providers in Wisconsin typically are not adequately trained to recognize and treat the health problems associated with farming as a pro-



fession nor are providers routinely assuring that agricultural workers are receiving preventive health care and education.

Partners in Agricultural Health, a project located within the service areas of Adams, Juneau, and Sauk Counties in central Wisconsin and developed by a network consisting of the Rural Wisconsin Health Cooperative, all five area hospitals, all three county health departments, Southwest AHEC and the Wisconsin Office of Rural Health, will address the health promotion and disease and injury prevention needs of the farmers and agricultural laborers. The purpose of the project is to:

- enhance existing occupational health services within the three county public health departments and five hospitals,
- provide educational programs and screening services for farmers and others in agriculture,
- develop an interactive web-site to market services and provide educational information to farmers and agricultural laborers, and
- develop an educational program for health professionals regarding the unique health care needs of farmers and agricultural laborers.

Partners in Agricultural Health, based on the Agri-Safe model developed in Spencer, Iowa, will provide educational, screening, and secondary prevention services to farmers, their families, and agricultural

laborers at many locations, including: a) county fairs, b) commodity meetings, c) producers' meetings, and d) on the farm. Screenings will also take place in five hospitals' occupational medicine departments. A coordinator with an agricultural background and an administrative assistant will be the dedicated staff for the project. Additional staffing will be provided through the collaboration of the area's public health and hospital partners.

*Funding is pending from a federal Rural Health Outreach Grant along with substantial area local support. Special thanks to Cathy Frey for having the vision and energy to bring folks together to develop this project (as the former Southwest AHEC Executive Director).*

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### *Telecommunications Designed For CAHs*

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The State of Wisconsin's Bureau of Quality has received a grant from the federal Health Research Service Administration's Rural Hospital Flexibility Program to assist rural hospitals in becoming Critical Access Hospitals. A portion of the grant has been set aside for these hospitals, in cooperation with the Rural Wisconsin Health Cooperative, the Wisconsin Health & Hospital Association and the Wisconsin Office of Rural Health to collaboratively contract for consulting or technical services in the 1999-2000 grant period.

A proposal for telecommunications and telehealth consultant services from Health Tech Strategies has been selected through a competitive process to be made available to participating hospitals. The consulting firm, based in McLean Virginia, has assembled an unprecedented team of national experts on behalf of this project. They represent renowned leaders in areas of health care technology development, clinical applications of new telecommunications for health care, health services research and evaluation of new technologies, and applicability of governing federal laws, regulations, and programs.

As stated by HTS: "Of obvious importance in the implementation of a telehealth program are the financial considerations: what equipment is needed, what is the cost likely to be, by whom will it be borne, and what might be offsetting sources of revenue?"

The consultation includes the following deliverables:

- HTS will evaluate the requirements for use of electronic mail within the hospital and community, and over the Internet, for providers and other authorized users of the system.

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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- HTS will make recommendations for providing physicians with access to laboratory, radiology, and other clinical test results from locations outside the hospital (e.g., physician office or home).
- HTS will make recommendations regarding the use of telehealth technology in discharge planning and follow-up care.
- For each hospital, HTS will analyze the availability of community-level or regional public health data, including information on immunization. HTS then will analyze how local clinicians might gain easy access to those public health data using telecommunications and information technology.
- After having first assessed the local needs for various telemedicine applications at each hospital, the attitudes and concerns of local providers, the local telecommunications infrastructure, and the financial resources of individual facilities and communities, HTS will make specific recommendations regarding the use of telemedicine technology for direct provision of health services.
- HTS will evaluate the possible use of computer-assisted adjuncts to clinical decision making in each of the hospitals including using algorithms for emergency triage or diagnostic work up, or treatment and practice protocols and guidelines.
- Besides its possible role as a vehicle for providing telemedicine services, videoconference technology may be useful for administrative support and staff continuing education. HTS will analyze the options, taking into account available telecommunications infrastructure, its costs, and the likely cost of system upgrades.
- The ability to implement many of these services within a hospital is to a large extent dependent on the availability of reasonably priced, wide bandwidth access to the Internet. HTS will examine potential Internet Service Providers and telecommunications companies to determine which connections to the Internet and which providers will be best suited to the needs of each individual hospital.
- HTS will assess the economic benefit of accessing funding through the Rural Health Care Committee of the FCC Universal Service program, and assist CAH participants in the application process.
- HTS will outline the development of a website that could be used for a broad range of services (e.g., pre- and post-operative information, provision of information on drug interactions).

- HTS will be constantly vigilant with respect to the various emerging administrative simplification, data security, and privacy requirements.

*Other rural hospitals in Wisconsin who may like to access this group purchase consulting engagement (at their expense) should contact Tim Size at RWHC. Other hospitals should contact Neil Neuberger at HTS (703) 790-4933 or <nealn@hlthtech.com>.*

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## *Wisconsin Using Anti-Rural Federal Index*

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***The Federal Problem***--RWHC, the National Rural Health Association and rural hospitals have fought against the bias built into Medicare's Hospital Wage Index for over fifteen years. The Hospital Wage Index is intended to adjust for regional variation in labor markets, ***variation in the price of labor faced by employers***, but has long been understood to have major technical shortcomings. National politics very similar to those which suppress Wisconsin milk prices along with federal bureaucratic resistance to collecting the appropriate data have been major obstacles to reform. The flawed Hospital Wage Index is one of the key elements at the root of Medicare inequities being challenged by the States of Wisconsin and Minnesota in the federal courts.

***Fast Forward***--Wisconsin was looking for a wage index to adjust its Medicaid payments for nursing homes and chose the Medicare Hospital Wage Index as easily accessible and federally endorsed.

***Some Medicare History***--In February of 1985 (no, this is not a typo, the year was nineteen eighty five), the second year following the introduction of the current Medicare prospective payment system, the National Health Policy Forum at George Washington University hosted an invitational workshop on "PPS Design: Tackling Major Structural Issues." It was the National Rural Health Association's first opportunity to present a rural perspective that seemed all but absent from the initial design. On behalf of the NRHA, the Rural Wisconsin Hospital Cooperative presented testimony to "challenge the justice of a system based on two national rates perpetuating historical urban and rural payment inequities not related to legitimate wage or intensity differentials." ***RWHC requested the development of a model more sensitive to actual labor markets than one where the wage scale takes a nose dive at the urban county line.***

A senior representative of the Health Care Financing Administration (HCFA) responded with a belittling

"of course, all models have their boundary problems"; apparently he had forgotten that many, if not most mathematical models, allow for gradual approximations of change. Weeks later, Carolyn Davis, then head of HCFA, stated that they would answer questions about rural wages by the end of the year. Unfortunately, basic questions about equitable area wage designations remain unanswered.

In June, 1990, the Prospective Payment Assessment Commission (a predecessor to Congress's current Medicare commission, MedPAC) issued a special report estimated that the technical problems inherent in the Medicare Hospital Wage Index cause it to understate the cost of rural wages by three to five percent.

The Secretary of the Federal Department of Health and Human Services, Donna Shalala, has received from her own National Advisory Committee on Rural Health recommendations regarding the need to standardize wage data by area variations in occupational mix. "Just as the PPS market basket reflects the costs of purchasing an average mix of inputs, the labor market adjuster **should reflect the cost of hiring an average mix of employees**. The purpose of the labor market adjuster should be to reflect the difference between the prices in the particular labor market area and national average prices. The actual labor cost in a labor market area needs to be adjusted for differences in occupational mix so that hospital payments do not reflect the results of different hiring decisions made by hospitals in different labor market areas."

**WI Medicaid Problem**--The Wisconsin Medicaid program is currently in the process of implementing the use of the Medicare Hospital Wage Index to adjust Medicaid payments to Wisconsin skilled nursing facilities. Recognizing the substantial negative impact to some facilities, mostly rural, it chose to blend the "old" and "new" rates during a two year transition period from 1999 to 2001. In response to initial concerns raised by RWHC, the Wisconsin Medicaid program agreed for discussion purposes to recalculate the wage index, still using the federal methodology, with its own wage data for Wisconsin nursing homes. RWHC hoped that the relatively more homogeneous nature of nursing home labor would make the lack of an occu-

**NATIONAL RURAL HEALTH ASSOCIATION  
ANNUAL CONFERENCE, MAY 24-26, 2000  
HYATT REGENCY HOTEL, NEW ORLEANS, LA.**

New Orleans, LA., will host as members and other participants gather for the learning and networking experiences of "NRHA 2K: À bonne santé! (To good health)." Following the successful three-day format of last year's event, the conference will run Wednesday, May 24, through Friday, May 26, 2000, allowing attendees to take in New Orleans during the Memorial Day weekend. Visit [www.nrharural.org](http://www.nrharural.org) for more information.

pational mix adjustment (the main technical problem noted above) less of an issue.

For once, the theory proved to be correct. The published Medicare Hospital Wage Index for rural Wisconsin is currently .8759 (the national average is 1.000); the raw wage index for rural nursing homes, using Wisconsin nursing home data is .9800 (the state average is 1.000). Both indices were then adjusted for regional differences in case mix and base reimbursement rates and then rescaled so that both indices result in the same State expenditure. The result is that the rescaled index for rural hospitals is .945 when using Medicare data and .977 when using Medicaid data.

**Bottom Line**--You might now ask what's the beef; what is a difference of .032 (3.2%) one way or the other? Well .032 times \$334 million dollars in effected rural wages is ten million dollars a year in lost wage reimbursement for rural nursing homes in Wisconsin. Wisconsin needs to do the right thing; it needs to use nursing home data when calculating a nursing home wage index. We are hopeful Wisconsin will do the right thing. This analysis is also an important reminder of the technical shortcomings in the Hospital Wage Index--that the actual rural-urban differential in wages is significantly lower when differences in occupational mix are taken into account.

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**When We Win Medicare Equity, What Next?**

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From "What Are Fair Medicare Rates For Wisconsin?" by David Kindig, Director, Wisconsin Network for Health Policy Research in the *Wisconsin State Journal*, 4/9/00:

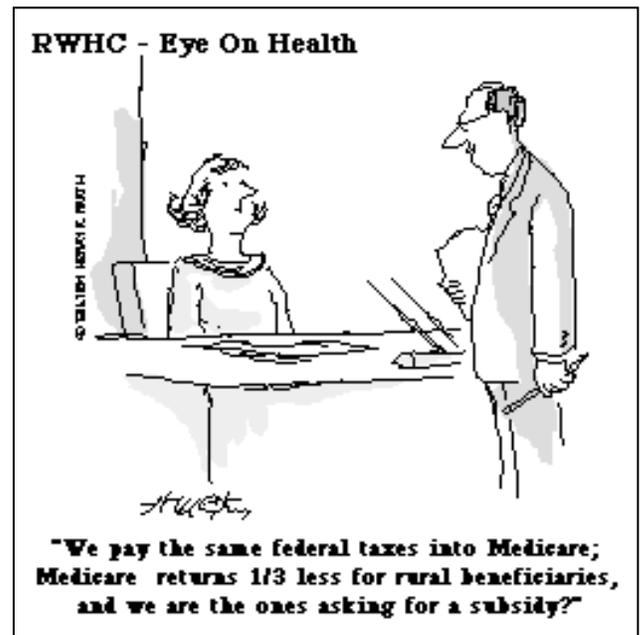
"The lawsuit filed last week against Medicare by Attorney General James Doyle highlights a large variation in Medicare spending across states, and correctly identifies Wisconsin as below average. The suit alleges that the relatively low rates paid to Wisconsin HMOs are invalid for two reasons: 1) they create gross regional disparities that are unrelated to the cost of providing health care or the medical need of patients, and 2) this causes injury to Wisconsin. It notes that Medicare HMOs in high reimbursement

states like Florida are able to provide to their members additional benefits like prescription drug, dental and vision coverage, or to reduce deductibles or copayments. Lastly, the suit claims that our lower rates have discouraged HMOs from coming into many Wisconsin counties, effectively denying Wisconsin senior citizens the higher benefits which are available to seniors elsewhere.”

“There is no doubt that such inequity exists. But the lawsuit is successful, what considerations should be built into more equitable rates? Current rates are based on historic spending patterns for hospitals, physicians and other services in a given geographic area, and result in high total expenditures in states like Florida. Higher expenditures mean more days in the hospital, more procedures and more doctor visits per Medicare recipient, and higher prices for the services. Yet many researchers believe that such higher utilization of services bears little relationship to better health outcomes. While the suit does not state what a fair rate should be, many may be left (in a ‘more is better world’) with the impression that Wisconsin’s payments should be simply increased to be as high as Florida from an equity perspective. But if a successful suit requires Medicare rate reform, are much higher rates for Wisconsin ‘fair’ and are they good for the state? Perhaps not.”

“**Maybe the states with expenditures higher than Wisconsin are too high.** Health spending in the United States is the highest in the world, and ever increasing expenditures are causing some businesses to eliminate health insurance, adding to the growing number of uninsured. High spending states will be at the extreme end of international and domestic health expenditure. High probably means unnecessary services or inflated prices, for both HMO and fee-for-service patients.”

“**Maybe Wisconsin (and other Midwestern states like Minnesota) are national benchmarks for value.** With low rates of spending, and quite favorable outcomes, perhaps Medicare policy should encourage other states to move to our result of good outcomes at moderate costs, rather than encouraging us to be less efficient. A recent study shows Wisconsin to be the third best state in terms of health quality, and at the bottom in health spending per person (all persons, not just Medicare). This ‘value advantage’ should be helpful to state taxpayers who pay for state employee health benefits and Medicaid, and to private businesses which provide health benefits to their employees. The result is that businesses in Wisconsin are more economically competitive and our uninsured rate is among the lowest in the country.”



“**Maybe we need fewer health dollars in Wisconsin than some states because we invest more in non-medical determinants of good health like education, income, and the environment.** There is increasing evidence that such investments are equal in importance to medical care, and Wisconsin’s high health quality may reflect in part our relatively high commitment to these other sectors. Perhaps we have a more balanced and more efficient health investment portfolio than other states.”

“I do not mean to argue that being below the mean is fair or correct. I hope the Attorney General’s suit is successful. Wisconsin’s seniors deserve prescription drug coverage as much as their retired friends in Florida. But if we won the suit, what might we argue correct policy to be? If Wisconsin were to receive more Medicare dollars, should they come from increased taxes, or from reductions from high expenditure states? If such reductions were warranted, shouldn’t they be applied to fee-for-service rates (still the major component) as well as to HMOs?”

“If we did receive more dollars, should they be used to increase the amount or price of basic services, or should they be dedicated to uncovered, needed services such as prescription drug benefits, better mental health care, more prevention, or an expansion of long term care? One researcher has estimated that if all states were paid the Medicare median amount, \$20 billion per year would be saved, which would go a long way to covering prescription drugs nationally for all elderly, not just those in HMOs.”

“Before we say simply more is better, we need to be sure what is fair and needed. Wisconsin may have health value lessons that the entire country might well emulate.”

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### *1<sup>st</sup> Medicare Justice Coalition Court Hearing*

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The first hearing on the Medicare Justice Coalition (MJC) Lawsuit has been set for Thursday, May 18<sup>th</sup> at 10:00 am. The Hearing before Senior Judge Donald D. Alsop will be held in Courtroom 3 of the Federal District Court Building located at 316 North Robert in downtown St. Paul. The hearing will deal with the Government’s request to dismiss the Medicare Justice Lawsuit. All MJC members and persons concerned about bringing equity to Medicare funding are urged to attend and support the lawsuit.

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### *A Proposal to Save Rural Home Health*

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From “Preserve Access To Rural Health Care With ‘Critical Access HHAs’ ” by Bruce Cummings and Linda Abernethy, in *Rural Health News*, Winter 2000, <[www.muskie.usm.maine.edu/mrhrc/MRHRCoverview.html](http://www.muskie.usm.maine.edu/mrhrc/MRHRCoverview.html)>.

“We think there is a creative solution to the crisis facing small, non-profit, rural home health agencies: a ‘Critical Access Home Health Agency’ designation,



coupled with an alternative payment methodology. Just as Critical Access Hospitals were established to respond to changing health care economics in rural communities, Critical Access Home Health Agencies can preserve access to Medicare-certified home health and hospice care in rural areas.”

“Across the United States, home health agencies are reeling from the Interim Payment System (IPS) created in the 1997 Balanced Budget Act. Nearly 2,500 agencies--out of 10,444 home health providers operating in 1997--closed between October 1, 1997, and August 18, 1999, according to the Health Care Finance Administration. In a study of 181 hospital discharge planners by the Office of the Inspector General, more than half of the respondents indicated they had difficulty placing their sicker patients--those with high costs, with IVs, with multiple chronic illnesses, those requiring more intensive nursing care--with home health agencies.”

### *Interim Payment System Hurts Rural Home Health*

“The IPS uses 1994 cost data to set new per beneficiary caps and cost per visit limits. These limits are not adjusted for inflation, case severity or complexity, geographic distances, or special services or equipment. As a result, IPS has had a devastating impact on home health agencies generally, and particularly on older, non-profit, and rural visiting nurse organizations. Capping costs with 1994 data penalizes agencies with historically low costs and utilization patterns. As The Wall Street Journal reported in Proposed Bill Aims to Help Out Ailing Home Health Industry, (February 11, 1998): ‘[The IPS] hurt efficient agencies more than those that have overused and abused the system in the past, because the lean ones have little fat to cut.’ ”

“While HCFA and Congress had a proper concern with wasteful practices and fraud and abuse perpetrated in certain regions by some agencies, the instrument chosen to ferret out the miscreants, the IPS, has also damaged or destroyed many ethical and efficient providers. Especially hard hit are small, non-profit, rural home health agencies.”

### *Rural Home Health - Same Nation, Different World*

“Rural non-profit home health agencies face extraordinary challenges because of their large service areas and low population densities. Rural home health personnel often have to travel many miles over secondary roads to serve a small number of clients--sometimes a single client in one community--before proceeding to the next client who may live dozens of miles away. In an urban or suburban setting, by contrast, home health personnel may be able to see multi-

ple patients within the same housing complex or within the same neighborhood. The IPS does not account for the geographic distances and limitations which impinge on staff productivity and increase travel-related expenses.”

“In many rural areas, the home health agency is often a surrogate for state or county health departments, providing a variety of public health and clinical services that would not otherwise be available. Indeed, a rural home health agency may be the only health care provider in certain areas. More commonly, the agency is the principal link between homebound frail and/or elderly patients and often distant medical resources. The IPS does not account for any of these special circumstances.”

#### *Remedy: Critical Access Home Health Agency*

“We propose that qualified rural providers be permitted to apply for special federal/state designation as a ‘Critical Access Home Health Agency,’ patterned after the ‘Critical Access Hospital’ category recognized within the Balanced Budget Act. Like the hospitals, home health agencies that obtain a ‘Critical Access’ designation would receive full reimbursement from Medicare for all reasonable costs and could receive full reimbursement from Medicaid at the discretion of the individual state’s Medicaid authority. If the home health agency also was certified by Medicare as a hospice provider, the hospice-related services would be included in the agency’s cost report and receive full recognition.”

“This designation would become available effective immediately and full-cost reimbursement would be made retroactive by Medicare to the onset of the agency’s participation under the IPS. Critical Access Home Health Agencies would be exempt from the PPS slated to become operational October 1, 2000.”

“The designation would be permanent, unless the agency lost its privilege to participate in the Medicare home health and/or Medicare hospice program(s); failed to meet the Medicare ‘Conditions of Participation’ as a home health agency and/or hospice; or, failed to maintain the appropriate license(s) from the relevant state authority. We suggest that agencies meet these four tests for eligibility:

- Must be located within a rural area and predominantly serve a rural population (using same definition for ‘rural’ as Critical Access Hospitals);
- Must have operated continuously and without interruption since 1990 as a Medicare-certified home health agency using the same Medicare provider

number (no time basis or restriction with respect to hospice certification);

- Must accept patients without regard to insurance status/ability to pay;
- Must be part of a Critical Access Hospital, Rural Health Clinic, Federally Qualified Community Health Center, or county or district public health department, or an affiliated corporation held by the same parent organization, or be recognized by the appropriate state health authority as an essential provider of home health services to a rural population within a defined geographic area.”

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#### *RWHC Seeks Health Information Manager*

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RWHC is seeking a Health Information Manager to supervise day-to-day operations management and consultation to the Credentials Verification Service and the Quality Indicators Program (a JCAHO Performance Measurement System). An expertise in JCAHO and NCQA standards is required as well as an ability to interpret and apply new or revised standards. Work experience in the hospital and/or managed care settings is also essential along with an understanding of rural health issues. The Health Information Manager also serves as a key resource; providing consultation on health information issues to member hospitals as well as other RWHC staff. Candidates should contact Bonnie Laffey, Director of Programs & Services, by submitting a resume via mail or email [blaffey@rwhc.com](mailto:blaffey@rwhc.com).

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#### *Bucky Badger’s Amazonian Transformation*

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A periodic *Eye On Health* feature are excerpts of letters from Dr. Linnea Smith from the Yanamono Medical Clinic in the remote Amazon basin of northeastern Peru. The clinic operates with grass roots support from family and friends and many others. AMP is a non-profit, tax-exempt organization. Donations are welcomed c/o: Amazon Medical Project, Inc., 5372 Mahocker Rd., Mazomanie, WI 53560.

“Yanamono, Late March: Well, the biggest news here is the weather (some things are the same, world over), which for us means the water level. We are now at the time of year when the Amazon can rise as much as a foot a day. According to my journal, at this time last year, only three of the steps were still above water; to-

day eight steps are dry. Of course, April is when the water really gets to moving up, but even so, we at least will not be underwater for as long as last year.”

“A few weeks ago, an older widowed woman who is raising a grandchild or two, came in the early morning to pick up my laundry. After she left, I realized I had forgotten to put in a towel that I wanted washed, so I figured I'd drop it off on the way to work. However, just before breakfast, there was a tap at the door, and when I opened it, there stood Fianita, the six-year-old granddaughter. ‘What did you want?’ she asked me. ‘Did I call you?’ I responded. ‘Si,’ she said. ‘Oh well, then, here's the towel I forgot,’ and I gave it to her and she took it with a happy grin and bounded down the steps. You can explain it to me.”

“In late January, a small crew of Rotarians came back to the Amazon, this time to dig wells. The one at the clinic has always gone dry when the river is low, and we generally have to haul water from the river for three or four months a year, which is a nuisance. Even so, we are not as bad off as some people. Edemita, my source for local news, tells me that at Santa Marta and Sapo Playa, when the river is low and the channel on which the villages are located dries up, the women there have to walk as much as two hours to reach the river. This means that they make this hike every single day until the river comes back up, hauling their laundry with them, and bringing water for drinking and cooking in five-gallon pails balanced on top of their heads. No wonder the women age quickly around here.”

“So the Rotarians dug a new, deeper well at the clinic, and put in two more, one at Sapo Playa downstream, and one at Las Palmeras, the Yagua village right across the stream from my house. We'll see how they hold up when the river is really low, but the idea seems to me to be a great one. In early March, three more Rotarians came to build roofs over the pumps installed by the earlier crew. Tyler's command of Spanish proved more than adequate to relieve me of the chore of having to translate. Plus two or three weeks in a row when Spring Break crews of students from various universities showed up, all full of energy.”

“And then besides all that, simultaneous with the building crew arrived a gang of University of Wisconsin alumni. They brought Wisconsin cheese and wine and enough Bucky Badger t-shirts (Bucky is the University of Wisconsin logo) to outfit all the lodge employees, all the clinic employees, and I don't know how many of our clinic patients. (I gave one to the woman who does my washing, and she proudly reported the next day that she had cut it up to make underwear out of it; she was thrilled to have underpants

to wear, so I guess that that Bucky won't mind not seeing the light of day.)”

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### *Ed Harding the Administrator at Columbus*

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Sandra Roof, President of the Board of Directors at Columbus Community Hospital, has announced the appointment of Ed Harding as CEO effective April 10<sup>th</sup>. Mr. Harding graduated from the University of Wisconsin in 1985 and took his master's degree in Hospital and Health Care Administration from the University of Minnesota in 1990. Mr. Harding was recruited from Clinton, Iowa's Mercy Medical Center where he was Vice President of Planning, Marketing and Professional Services. Ed is a Fellow of the American College of Healthcare Executives and enjoys coaching soccer, football and baseball. Chase Hunter Group, a Chicago executive search practice, completed the national search within 90 days.

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### *Online Glossary for Health Care Policy*

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Thanks to the Washington DC based health policy organization, the Alpha Center, there is now a great online *Glossary of Terms Commonly Used in Health Care* at <[www.ac.org/httpdocs/glossary.html](http://www.ac.org/httpdocs/glossary.html)>.

The Glossary goes from **access** to **withhold** along with a list of health care acronyms, from **AAMC** to **VIRHN**. The glossary is intended to be used primarily as a reference guide for health care policy makers. It is periodically updated and edited to reflect the changing lexicon of health care terms and concepts. Sources of definitions include the publications/articles listed below, as well as personal communication with experts in health care policy and service delivery. Support for the development of this glossary has been provided in part by the U.S. Agency for Health Care Research and Quality, User Liaison Program.

“The society which scorns excellence in plumbing as a humble activity and tolerates shoddiness in philosophy because it is an exalted activity will have neither good plumbing nor good philosophy... neither its pipes nor its theories will hold water.” John W. Gardner