Rural Wisconsin
Health Cooperative

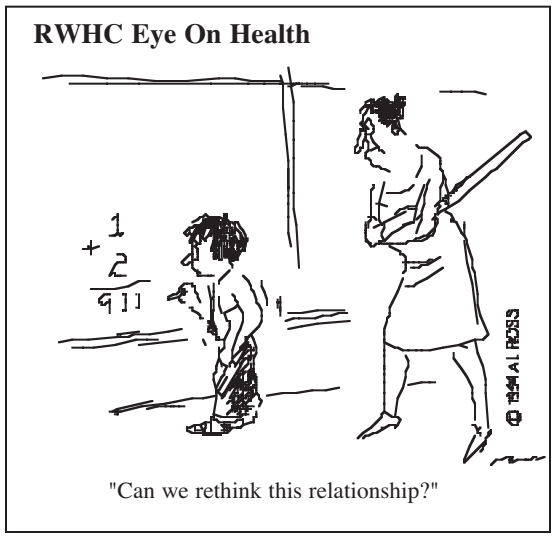
Eye On Health

Review & Commentary on Health Policy Issues from a Rural Perspective - August 1st, 2001

What Is Needed Next For Medicare?

From *Rural Hope For Medicare—Become More A Partner, Less An Adversary*, presented by Tim Size, RWHC Executive Director, to the Capitol Area Rural Health Roundtable, Washington, D.C., 7/25/01; full text at http://www.rwhc.com:

During the second year (1985) of Medicare's Prospective Payment System (PPS), at an invitational forum on "PPS Design: Tackling Major Structural Issues," I requested the development of a model more sensitive to actual labor markets than one where the wage scale takes a nosedive at the urban county line. A senior representative of the Health Care Financing Administration (HCFA), responded with a less then helpful "get used to it, all models have their boundary problems." Weeks later, the then head of HCFA stated that they would answer questions about rural wages by the end of the year. We are still waiting.



"Can we rethink this relationship?"

For rural providers, the fundamental inequity in PPS is a result of our not having been at the table back in the early 1980s when the foundation for the PPS model was set. Put less kindly, "rural advocates were asleep at the switch." Urban advocates were successful in seeing that their hospitals were compensated for the effects of their local markets through disproportionate share payments and the use of a wage index. Rural hospitals were lumped into statewide markets and were not compensated for the effects of their local markets—markets with low volume and requiring high overhead. Low volume and high fixed costs kill rural hospitals—it is a "condition" that they face, just as urban hospitals face having a large safety net requirement and high wage rates.

The failure of Medicare to address rural market conditions in a manner consistent with its recognition of urban conditions has led to Medicare operating margins disproportionately lower for rural providers, hospitals in particular. It has undermined the credibility of the Program and cast the federal government as an adversary to rural communities as they seek to provide local health care.

Turning away from legislative issues I would like to briefly comment on Medicare's administration, the Centers for Medicare and Medicaid Services (CMS). For those of us "in the trenches," it has appeared easier for too many to play off of embedded stereotypes about the so called failure of rural hospital boards and administrators then to look inward at Medicare's historic and systemic failure to design and manage an equitable Medicare program. Secretary Thompson with the early symbolic act of changing the name of HCFA to CMS has told us that he is committed to a cultural shift unprecedented in the agency's history.

Notwithstanding the cynics, CMS can best address its fiduciary responsibilities by continuing its shift from provider adversary to provider partner. Rural communities need a fundamentally new federal relationship if they are to prevail over an intimidating array of major challenges. This is not to blur the distinctly different set of responsibilities between payer and provider but it is to say that collaborative alternative models exist and must be explored.

"It is not the strongest who survive, or the fastest. It is the ones who change the quickest." Charles Darwin

Thompson Brings Science To Patient Safety

From "New Evidence On Proven Patient Safety Practices", a press release from the Agency for Healthcare Research and Quality, 7/17/01; copies of the full report can be found at <www.ahrq.gov/>:

"The Agency for Healthcare Research and Quality (AHRQ) released new evidence on practices that could improve patient safety throughout the nation's health care system. The evidence report, compiled by AHRQ's Evidence-based Practice Center at the University of California San Francisco/Stanford University, reviewed the evidence on a total of 79 patient safety practices. It lists 73 that are likely to improve patient safety and describes 11 that the researchers considered highly proven to work but are not performed routinely in the nation's hospitals and nursing homes."

" 'We are sharing these findings with health care administrators, medical directors, health professionals, and others who are responsible for patient safety programs in the institutions where they work,' said HHS Secretary Tommy G. Thompson. 'The nation's health care leaders need to know what the science says about where the opportunities exist to make patient care safer right now.' "

"The report, *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*, is the result of a comprehensive review of the literature from medicine, aviation, and other relevant fields. Among the 11 highly proven practices are giving patients antibiotics just before surgery to prevent infections, using ultrasound to help guide the insertion of central intravenous lines and prevent punctured arteries and other complications, and giving surgery patients beta blockers to prevent heart attacks during or after the operation."

"The report also is being provided to members of the National Forum for Health Care Quality Measurement and Reporting which plans to use this information to develop a list of measures that patients throughout the nation can use to determine the actions that hospitals and/or health care facilities have taken to improve safety."

"To compile the 640-page report, researchers reviewed the medical and other scientific literature on safety practices and consulted with health care experts. They focused on issues relevant to care delivered in hospitals (where the risk of medical errors is significant) and on prevalent diseases and procedures rather than on specific diagnoses. They chose to exclude practices for which little or no scientific studies could be found to help assess their usefulness as well as practices that only affect the care of patients with a single diagnosis."

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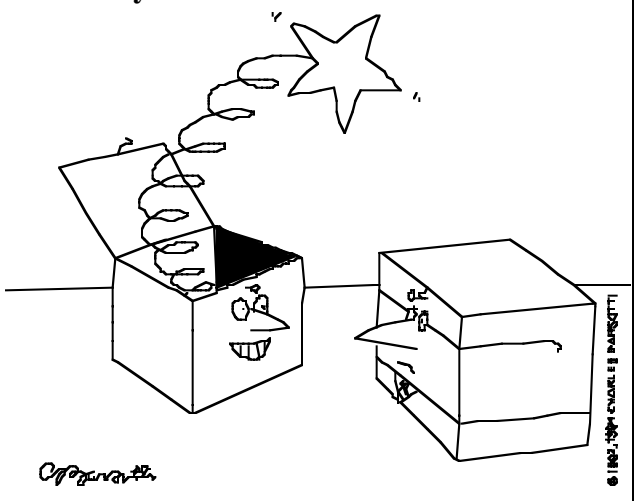

"It's great being a systemic error; they know you're coming but not when."

"Researchers were surprised that more than a dozen practices long considered important by patient safety experts—including the use of computerized order entry systems, improved handwashing compliance, and changes in nurse staffing ratios—haven't been sufficiently studied and therefore didn't make the top 11 list. 'Even though many of these practices are clearly valuable in improving patient safety, the report shows that there needs to be more research in these areas so that we know more about which practices are most effective and how complex or costly they would be to put into place,' said AHRQ Director John M. Eisenberg, M.D."

Errors-Why We Don't Act & How We Can?

From "Improving Quality, Minimizing Error: Making It Happen--A Five-Point Plan And Why We Need It" by Elise C. Becher and Mark R. Chassin in *Health Affairs*, May/June, 2001:

Barriers To Change

"The effort to create, disseminate, and put in place the numerous new systems and approaches to reducing errors and improving quality is daunting. It

demands that all parts of the delivery system—hospitals, physician practices, integrated delivery systems, nursing homes, and hospices—devote their scarce resources to the task. It will require a substantial investment of time, talent, energy, and money. The task is made much more difficult by the fact that there are no exemplars of excellence, institutions, or practices that have succeeded in achieving extremely low rates of errors across all dimensions of quality and across all of the services they provide. If the evidence of errors and quality problems is so clear and compelling, what is standing in the way of improvement?"

Little demand for higher quality. "Neither consumers nor their representatives demand higher quality or fewer errors. Survey data indicate that consumers want wide choice among doctors and hospitals, low cost, and unimpeded access to their caregivers; they do not ask for information about quality, health outcomes, or rates of errors. Neither public nor private purchasers of care have used their purchasing power to demand high quality, preferring to focus their efforts on obtaining low prices. Some voices from the purchaser community are calling for greater attention to quality. Their initial efforts, however, are not focused on obtaining data on performance or improvement. Rather, they will provide information to employees on surrogate measures, such as the volume of services hospitals provide. Even in those rare circumstances when data on quality are available, research shows that neither consumers nor managed care companies use them to select higher-quality providers."

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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Lack of information technology. "Another barrier is the high investment cost of creating the necessary measurement and improvement systems. Information technology (IT) does not yet link the myriad sources of information required to understand quality of care. The price tag is immense for developing and deploying a system to integrate data from doctors' offices, clinical laboratories, hospital diagnostic imaging facilities, freestanding ambulatory surgery centers, radiation therapy facilities, and hospital medical records. And this list is not exhaustive. Although some commercial products are available to accomplish this task on a small scale, such systems are not available for medium-size or large hospitals, health systems, or populations. Further, assembling computerized data is just the beginning of quality measurement. In most circumstances, data from harder-to-reach clinical sources must be added to the more readily available automated data to produce measures clinicians will believe and on which they are willing to act. Finally, understanding how to alter complex clinical care systems to improve performance, intervening to improve, and sustaining that improvement require yet additional investments."

Skewed financial incentives. "Even for organizations that are financially secure enough to consider investing in quality improvement, today's health care payment environment is perverse. Even when quality improvement and cost savings can be achieved simultaneously, the cost of the improvement is borne by the health care provider, and the savings are often realized by another party. If a hospital reduces the number of unnecessary hysterectomies performed by its physicians, unless it is in the unusual situation of receiving a large share of its payments in the form of capitation, the savings from this improvement will accrue to a managed care company, to a private employer, to Medicare, or to Medicaid. Likewise, a state-of-the-art management program for improving quality and functioning in patients with asthma or heart failure is likely to reduce the number of hospital admissions and, again, reduce hospital revenue."

Policy Directions

"To make substantial progress toward improving health care quality, we call for a multifaceted strategy that involves all parties."

Education. "First, to increase public demand for higher quality and fewer errors in health care, more vigorous efforts to educate the public about quality might be effective. Public and private employers could initiate such efforts by helping their employees

to understand that they are not getting the full potential benefit from available health care—that quality problems imperil their health. Organizations representing consumers also have a responsibility in this regard; we note that the problem of overuse has gone nearly unrecognized as a major quality problem by the general public."

Reduced expense. "Second, the cost of creating tools and systems to measure and improve quality must be reduced. The federal government should invest far more than it does today in research and demonstrations to build, evaluate, and disseminate the tools that hospitals, physician practices, nursing homes, and integrated delivery systems need. Private foundations should also participate. This effort is exactly analogous to the enormous postwar investment in the National Institutes of Health (NIH), which led to today's new drugs, medical devices, and treatment regimens. If we are ever to realize the full potential benefit of that investment, we will have to make a large, sustained commitment to investing in quality improvement tools and systems."

Financial rewards. "Third, to accelerate the pace of adoption of these tools and systems, purchasers of health care need to develop payment methods that reward excellence in quality. At present, no such method exists. Instead, the traditional fee-for-service mode of payment encourages overuse. Capitation or per case payments encourage underuse. Most providers of care face a bewildering array of payment methods, each with its own set of perverse quality incentives. A large number of valid measures of quality exist today. Purchasers should pay more for high-quality care. They could begin by reserving a portion—say, 10 percent—of their payments for particular services as a premium for high quality. Based on objective measures of quality for these conditions (for example, the proportion of heart attack survivors who are treated with beta-blockers), providers who most often provide all components of effective care would receive higher payments than those with poorer performance. Similar incentives should be designed for controlling overuse and misuse problems."

State regulation. "Fourth, although regulation is out of favor, state governments continue to administer programs to identify and punish physicians and other health professionals whose performance is egregiously poor. These programs require substantial improvement. They now devote most of their resources to punishing physicians who abuse patients sexually, traffic in illegal drugs, or violate other criminal laws. They should pay far more attention to identifying and sanctioning physicians who routinely endanger patients because the quality of their care is so inadequate."

"State governments can also facilitate the collection, analysis, and public dissemination of key data on health care quality. More state agencies should replicate the program established in New York State more than a decade ago to improve mortality following cardiac surgery. The state health department receives data from hospitals on every patient who undergoes cardiac surgery, verifies their accuracy, and publishes risk-adjusted mortality data by surgeon and hospital annually. The improvement efforts undertaken by hospitals throughout the state have resulted in dramatic statewide declines in mortality following coronary artery bypass surgery."

Provider leadership. "Finally, health care providers should seize the leadership in error reduction and quality improvement by establishing evidence-based measures for all three kinds of quality problems. They should create model programs for improvement, document their impact, and disseminate their successes. Despite the high cost of such investments and the lack of payment schemes that reward high quality, it is nevertheless possible for providers to craft strategies that take advantage of those instances where quality improvement does result in a favorable impact on the hospital's or system's bottom line. If a few such institutions made quality improvement their highest priority in this way, their successes could motivate others by demonstrating what is possible."

"An immense reservoir of professionalism still exists among physicians, nurses, and other caregivers. It is waiting to be effectively mobilized in the service of quality improvement. A great opportunity exists for those institutions that can ignite this enthusiasm and show all of us what truly high quality health care can be."

Regional Consortium Makes A Difference

From "Reason to Hope on Health Care" by David S. Broder" in *The Washington Post*, 6/10/01:

"It was a gathering of lions, a meeting any health care lobbyist would have paid big money to crash. Seated around the table at a local hospital the other day were Tommy Thompson, the secretary of health and human services; the most influential senators in their parties on health issues, Democrat Ted

Kennedy and Republican Bill Frist; Dr. Mark McClellan, a health policy adviser to President Bush; assorted senior staffers from Washington and health experts from around the nation."

"The most remarkable thing about the meeting was not the participants but what was said -- and not said. For six hours of intensive discussion, what political Washington considers the most important health care issues -- the patients' bill of rights and Medicare drug benefits -- went unmentioned."

"Instead, the visitors listened and learned from the team of briefers about error rates in dispensing pharmaceuticals, the number of infections contracted in hospitals and even about what Toyota Motor Corp. might have to teach Americans on the practice of medicine."

"The host of the gathering--and the man as passionate about health care reform as anyone at the table--was Treasury Secretary Paul O'Neill, who in his earlier life as the CEO of Pittsburgh-based Alcoa had been instrumental in forming the Pittsburgh Regional Healthcare Initiative, a cutting-edge consortium of providers, consumers, insurers and employers whose goal is to demonstrate that sense can be made of the hodgepodge that is the American health care system."

"Ever since he came to Washington, O'Neill has been telling the president, his Cabinet colleagues and lawmakers of both parties that they need to see what is happening in health care in southwestern Pennsylvania."

"The consortium was formed three years ago, with O'Neill and Karen Wolk Feinstein, president of the Jewish Healthcare Foundation, as its heads. It now includes 32 hospitals, four major insurers, more than 30 business executives, the Pennsylvania attorney general and hundreds of physicians. Its work is supported by the Centers for Disease Control and a $1 million grant from the Robert Wood Johnson Foundation."

"While most of its projects are incomplete, O'Neill told the visitors that enough has been learned to convince him that 'with the money we are spending in this country, we have the resources to provide top-quality medical care for every American.' "

"That can happen, the conferees were told, only if the health care system is turned on its head -- not by changing its financing, as the Clinton administration proposed -- but by focusing all its parts 'on the patient at the point of care.' "

"That sounds like a cliche, but it is not. As the head of nursing at one of the participating hospitals said, 'Nurses now serve the hospital, not their patients,' distracted by other duties from being the front-line caregivers."

"Another example: Medical records now are kept in the offices of doctors and hospitals, often unavailable to others. The consortium is working with electronics firms to develop a "smart card" with an individual's entire medical history and background on it, including not only allergies but whether he or she uses a seat belt and has a smoke alarm. Each person would decide what information to share, but an attending physician could be alerted not to order tests already performed elsewhere and not to give a drug that wars with one already being taken."

"The effort to improve quality and reduce costs involves collecting and sharing data on medical outcomes. Initially reluctant, the participating, highly competitive doctors and hospitals agreed to report to each other the outcomes of their hip and knee replacements and their cardiac surgeries. Come to find out, one out of six heart patients has to be readmitted, half of them within a week of being discharged. Now the physicians are trying to identify, as a group, which patients should be hospitalized longer to avoid the trauma and expense of the return hospitalization."

"Similar quality and cost controls are being applied to eliminate errors and delays in dispensing drugs and avoiding the all-too-prevalent hospital infections."

"The model for much of this is Toyota, which has the knack of competing on both quality and cost by inculcating a doctrine of 'error-free' auto production. Toyota makes each employee feel responsible for meeting that standard and for signaling loudly to superiors when something in the system is preventing the worker from doing a good job."

"Frist and Kennedy left Pittsburgh talking about federal legislation that would create a center in Thompson's department for 'quality improvement and patient safety,' expand the database needed to identify and eliminate frequent medical errors, and provide legal protection for people in the health care system who voluntarily disclose where the problems are."

"It's a different and hopeful way of thinking about one of the major challenges this nation faces."

Wisconsin Ready To Move On Dental Crisis

From "Dental Care Access in Wisconsin," by Senator Rodney Moen, Representative David Ward and Laura Rose, Deputy Director, WI Legislative Council as published in the Wisconsin Network For Health Policy Research *Issue Brief*, June 2001:

"Wisconsin currently experiences a significant problem with access to dental care services for its residents. Contributing to this problem is a shortage of dentists. The Wisconsin Dental Association, a statewide trade association of dentists, recently commissioned a study on the dental workforce shortage that shows that, between the years 2001 and 2010, Wisconsin will experience a net loss of 297 dentists, which represents approximately 10 percent of the current workforce of 2,979."

"Although the shortage of dentists affects everyone, low-income populations, such as those receiving Medical Assistance (MA) and BadgerCare, face a greater problem than other populations with regard to access to dental services. Data from the Wisconsin MA program shows that 57.6% of licensed Wisconsin dentists were MA-certified as of June, 2000. Of this number, 42.3% of certified dentists submitted claims to the MA program in state fiscal year 2000. For that same year, only 22% of Wisconsin's MA population received any dental services. These access rates are significantly lower than those of the general population.

"The Wisconsin legislature responded to the dental access problem by establishing the Joint Legislative Council's Special Committee on Dental Care Access in the summer of 2000. The Committee developed two pieces of legislation, which have been introduced into the 2001 Wisconsin legislature as 2001 Senate Bills 166 and 167, and Assembly Bills 366 and 367. Among a number of recommendations, those which address issues related to the supply of dental personnel, are as follows:"

- Change licensure procedures to make it easier for dentists from other jurisdictions to move to Wisconsin and obtain a dental license.

- Increase the number of slots at the Marquette University School of Dentistry for Wisconsin residents qualifying for a tuition subsidy from 25 per class to 40 per class.

- Allow dental hygienists to practice in a variety of settings without a dentist in the facility and without a prescription from a dentist if the dental hygienist meets additional experience and educational requirements.

- Allow dentists to delegate dental procedures to dental hygienists and dental assistants, subject to certain restrictions."

"The Committee reviewed the low participation rate among licensed Wisconsin dentists in the Medicaid program. Concerns were raised by dentists regarding the inadequacy of Medicaid reimbursement and the burdensome administrative requirements imposed by Medicaid. To address administrative concerns, the DHFS established a working group that is making progress on these issues. In addition, the Committee made a number of recommendations with regard to the Medicaid program, including:

- Increase the Medicaid reimbursement rate for dentists to the 75th percentile of the fees from the American Dental Association fee schedule for the region that includes Wisconsin.

- Allow dental hygienists to be reimbursed under Medicaid for services that are covered by Medicaid and that are within the scope of practice of a dental hygienist.

"These Bills should result in significant discussion of the issue of dental access in Wisconsin by policymakers this legislative session, and increased awareness of this problem throughout the state."

"Rural" In The UW Plan; Action To Follow?

The University of Wisconsin Medical School's "Strategic Plan, 2001-2003," for the first time, identifies rural health as a priority program (one of seven). The plan states that "through the allocation of Medical School resources (fiscal, physical and human resources)" it will achieve specific three year goals. When presented to a recent State Rural Health Development Council meeting, the key question was asked--**"how do we know this isn't just a report headed to a shelf; how will effort and outcomes be evaluated?"** The rural plan is as follows:

"One third of Wisconsin's citizens live in rural communities and have health care challenges that represent particular issues for those communities. The problems of access to care, distance barriers to services, the burden of poverty and workforce development are increased in many ways in rural com-

munities. Additionally, the special nature of rural health in areas such as geriatrics, women's health and population health underscore rural health as a meta-issue. The combined resources of the Medical School and the University are used to augment opportunities in placing graduates in rural communities and in rural health related research."

"To improve high quality health services in rural areas through education and research, five areas are emphasized:

- Increase access of rural women to prenatal and perinatal care through interdisciplinary training and service programs with family physicians, obstetrician-gynecologists and general surgeons;

- Develop an informatics program for all providers statewide which will increase access of rural providers to information for clinical decision-making and planning of services;

- Recruit students to each Medical School and allied health class who might have a significant predilection to practice in rural communities and develop programs to help them sustain their interest in order to increase the likelihood that they will chose to practice in rural communities;

- Ensure understanding the health needs of rural communities is an essential part of student education regardless of ultimate specialty choice;

- Improve satisfaction of rural physicians through creative CME programs using distance education and other methods to overcome distance barriers. Finally, the Medical School should encourage teaching of students and residents by rural practitioners, and develop other ways to increase the contribution of rural physicians to the mission of the Medical School."

RWHC Eye On Health

Beginning To Regret What We Wished For?

From "Calling That Counts," an editorial by David Gergen in *The Washington Post*, 6/1/01:

"The civil service – the substructure that is so vital to day-to-day operations – is rapidly crumbling: 53 percent of the federal workforce will qualify for retirement by 2004; 71 percent of the government's senior managers can retire by then."

"And there's precious little new blood to replace them. A survey of the nation's most academically gifted college students - the Phi Beta Kappa graduates - found that only 1 in 10 rated the government as the employer of choice. Among the nation's public-policy schools, interest in government has also declined. According to Light, some 76 percent of those graduates sought public-sector jobs in 1973; two decades later, the number dropped to 49 percent; today it has dwindled to about 30 percent. And these are people supposedly being trained for public service!"

"The results are beginning to show. A failure to translate intelligence documents in a timely fashion left the United States surprised when Pakistan and India exploded nuclear weapons, according to one expert on language and government policy. A rise in vacancies at the Energy Department is jeopardizing management of the nation's nuclear stockpile, according to congressional testimony. Inexperience and inadequate oversight of outside contractors reportedly contributed to the loss of four NASA spacecraft bound for Mars in 1999. The press has reported that a cut in the staff at the Internal Revenue Service has brought a sharp curtailment in the pursuit of delinquent taxpayers."

"Several nonprofit organizations have begun to respond with serious studies of what can be done to fix things. But it's time for the rest of us-starting with the White House, Congress, the press, and alarmed citizens-to address these threats with the urgency they deserve. Let us continue our arguments whether government should be smaller or bigger. But let us also recognize that even if we whittle it back some more, the federal government will still be sizable-it stands at 18 percent of GDP right now-and the quality of people who serve will be vital."

"Do you want your air travel in the hands of men and women who actually know what they are doing? How about inspections of the food you eat? The drugs you take? Want timely intelligence reports on killers like Timothy McVeigh? Well, then, public service matters. We need to see it for what it is-a high calling-and inspire our young once again to answer."

Cigarettes As Economic Development Tool

From "Smoking Is Cost-Effective" at BBC News Online, http://news.bbc.co.uk, 7/17/01:

"The premature deaths of smokers has economic benefits, according to a controversial report commissioned by a leading US cigarette manufacturer. The report, drawn up for tobacco giant Philip Morris Inc, found that the Czech Republic saved about $147 million in 1997 through the deaths of smokers who would not live to use healthcare or housing for the elderly."

"Compiled as a cost-benefit analysis and delivered to the Czech Government, the study weighted the savings against the income tax lost and cost of caring for smokers before they died. However, tobacco industry opponents have attacked the report as an attempt to show that governments benefit from smoking related deaths."

"In a statement, Philip Morris said it 'deeply regrets' suggestions of the beneficial economic effects of smoking. The study 'was part of an ongoing debate about the economics of cigarette excise tax policy in the Czech Republic,' said a company spokesman. But, said Patti Lynn from the corporate watchdog Infact, 'even if it were true ... it's a scary logic on which to base policy.' Anti-smoking groups have also questioned the report's validity, as it assumes that if cigarette sales ceased, smokers would not spend their money on other goods."

"Tobacco companies have used similar arguments in the past to defend themselves against lawsuits from states demanding reimbursement for treating smoking-related diseases. However, last month a Los Angeles jury ordered Philip Morris to pay more than $3 billion to a smoker suffering from terminal cancer who said the company did not warn him of the dangers of smoking. The award was the largest individual punitive damage award ever against a cigarette maker."

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