

Review & Commentary on Health Policy Issues from a Rural Perspective - November 1<sup>st</sup>, 2001

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### Quality Data Needed About Quality Of Care

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This statement was written collaboratively by a number of health care leaders in southern Wisconsin as part of a discussion about a recently published report card but is solely the responsibility of *Eye On Health*:

The release of *Quality-Counts* report on the Safety of Hospital Care represents the culmination of a long and painstaking effort on the part of the Employer Health Care Cooperative, the Alliance. Many hospital representatives have worked with the Alliance as the elements of this report have been assembled. We represent urban and rural, public and private institutions. Despite the great differences in our size and in the populations we serve, we share a common concern about the meaning and usefulness of the data as it is reported.

As providers of health care, we share a common view that the kind of data that has been collected—specifically billing code data—does not provide a true picture of patient experience and outcome in a given hospital. We also think that this kind of data, while useful for a hospital to evaluate *potential* problems and to monitor the success of its own quality improvement initiatives, does not allow for direct comparison of one hospital to another.

We respect the Alliance and its leadership on their dedication to improving the quality of health care in our communities. The measurement of quality and safety in health care is of vital concern to us all and is

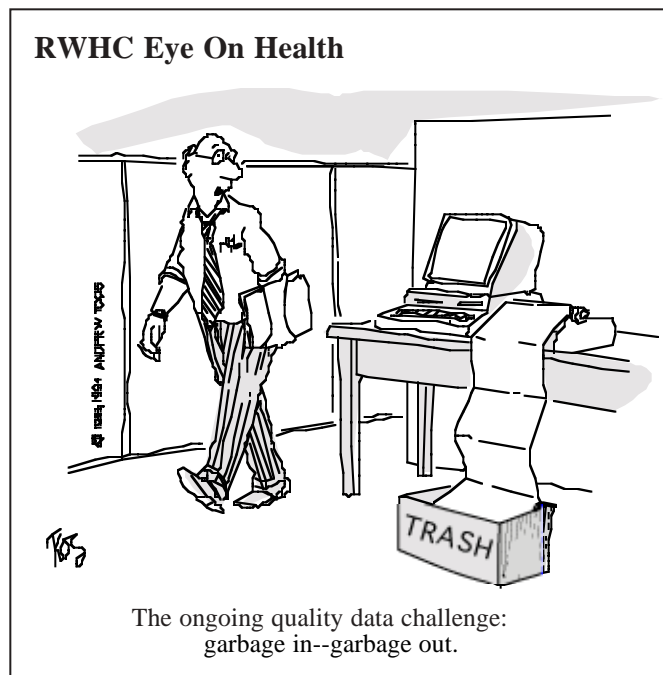
an aspect of health care that is accorded increasing time and effort in each of our institutions. Like the Alliance, we support public access to information that helps consumers make informed healthcare choices, but the problems with the *QualityCounts* report are numerous. As health care providers, we are not sure how to interpret the results of the report. Considering our own uncertainty, we believe that our patients are also apt to be confused by the report.

The collection of health care data that accurately reflects the quality of care is difficult; there is considerable controversy among experts about how and what to measure. Moreover, there is no agreement about how data can be used to compare one hospital to another. These considerations weigh on the interpretation of the Alliance report.

Our concerns lead us to urge area patients not to make decisions about where they receive their care based upon this report. If you find the results of the report disturbing

in any way, we recommend a discussion with your personal physician, before you change any health care choices.

We acknowledge that our response to the *Quality-Counts* report reflects a basic difference of opinion between the Alliance and its providers. In the end, we all share the goal of the highest quality care in the communities we serve. We will continue to work together to meet these goals and hope eventually to find a more universally acceptable method of providing useful health care information to Wisconsin communities.



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## Wisconsin Rated High For Quality Of Care

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From the “Quality of Medical Care Delivered to Medicare Beneficiaries: A Profile at State and National Levels,” by Stephen Jencks et al. in *JAMA*, 10/00:

“As concern grows that attempts to control the cost of health care will crowd out quality, evidence has also emerged that quality of care is and has been far more uneven than previously recognized. The public health report entitled *Healthy People 2010* showed wide gaps between public health performance goals and actual achievements on many measures. Reviews showed that there were major gaps in acute, chronic, and preventive care almost everywhere that studies have been done. More recently, a report from the Institute of Medicine showed serious problems of harm to patients from medical errors. Despite condition-specific and managed care-specific reports, there has been no systematic program for monitoring the quality of medical care provided to FFS Medicare beneficiaries.”

“Except for the clinical measures of the Health Plan Employer Data and Information Set (HEDIS) and the Diabetes Quality Improvement Project (DQIP) there is no clinical quality measure set in general national use. About 4 years ago, the Health Care Financing Administration (HCFA) began to implement a program to measure and track the quality of the care for which Medicare pays. Simultaneously, HCFA committed to using its peer review organization (PRO)

**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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contractors to systematically promote improved performance on the quality measures tracked under this program using a voluntary, collaborative, and non-punitive educational strategy.”

“This article describes the 24 initial measures used in this program and reports the baseline values measured in 1997-1999. The Medicare measurement system we developed includes most of the HEDIS clinical measures, but it addresses more conditions, measures more elements of care, and measures the care delivered to the 85% of Medicare beneficiaries who are covered under FFS. The sampling frame provides state-level results to target PRO activities, evaluates PRO and HCFA effectiveness in improving care, and creates a national picture of care under Medicare FFS.”

“Even though purchasers and beneficiaries are primarily interested in outcomes, we focused on measuring processes of care critical to outcomes rather than on measuring outcomes themselves. Five reasons drove this choice:

1. in comparison to outcomes of care, there is more consensus on appropriate processes of care and the target rates (nearly 100%);
2. measuring processes of care generally does not require the risk adjustment that has been so controversial in comparisons of outcomes;
3. it is easier for providers, practitioners, and plans to identify and fix the reasons why critical processes of care were not carried out than to determine why outcomes are not optimal;
4. many important outcomes take years; and
5. because significant, achievable improvements in outcomes are generally much smaller in relative terms than improvements in processes, unrealistic sample sizes are necessary to measure significant improvements in outcomes.”

**Methods**—“The clinical topics were selected using 5 criteria:

1. the disease is prevalent and a major source of morbidity or mortality in the Medicare population;
2. there is strong scientific evidence and practitioner consensus that there are processes of care that can substantially improve outcomes;
3. reliably measuring the delivery of these processes is feasible;

4. there is a substantial ‘performance gap’ between current performance and desirable performance; and

5. there is at least anecdotal evidence that PROs can intervene effectively to improve performance on the measures.”

“Using these criteria, we adopted or developed 24 process-of-care measures relating to primary prevention, secondary prevention, or treatment of acute myocardial infarction (AMI), breast cancer, diabetes mellitus, heart failure, pneumonia, and stroke.”

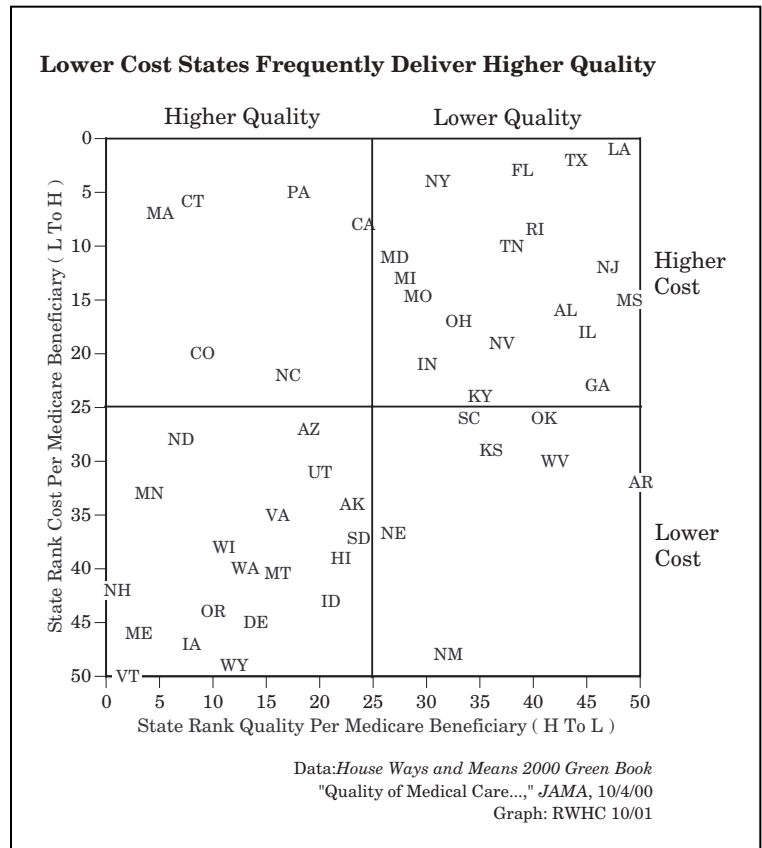
**Implications**—“This study provides strong evidence of a substantial opportunity to improve the care delivered to Medicare beneficiaries. Available data suggest that providing the services measured here could each save hundreds to thousands of lives a year, but more precise estimates of the effect of such improvement on beneficiary health are beyond the scope of this study.”

“The differences in average performance among states and regions are modest compared with the overall need for improvement. Nevertheless, the data suggest real underlying geographic differences in the way care is delivered to the Medicare FFS population. They also suggest that variations among states on individual measures are part of a larger pattern and not simply local variation. We do not yet understand the reasons for these differences or whether aspects of the systems in high-performing states can be easily replicated in low-performing states.”

**Limitations and Qualifications**—“These measures give a somewhat unbalanced picture of Medicare services. They overrepresent inpatient and preventive services, underrepresent ambulatory care, and scarcely represent interventional procedures at all.”

**Future Steps**—“Although it is customary to speak of holding providers, practitioners, and health plans accountable for the care they provide, it is at least as important to hold purchasers, whether Medicare or Medicaid or commercial or government employers, accountable for the quality of the care they purchase, because they are making continual and important decisions that potentially balance quality against expenditures.”

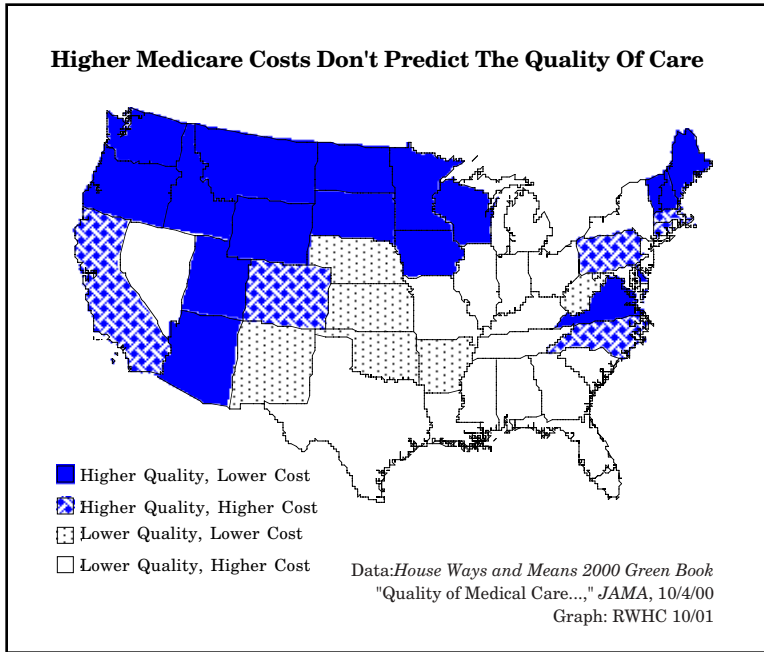
“HCFA intends to extend the Medicare clinical performance tracking system in 3 ways. First, for those measures based on medical record abstraction, we are now collecting a continuous sample large enough to



provide accurate trending of national data every few months, although too small to provide state-level estimates more than every few years. Second, we will collect enough data to make accurate state-level estimates every 3 years (synchronous with PRO contract cycles). This will allow us to evaluate the success of each PRO in meeting its major contractual requirement, which is to improve statewide performance on the measures. Third, we will extend the system to include other settings, such as nursing homes, home health agencies, and other providers and to include other clinical priorities.”

“Obviously, pervasive gaps between what is being done and what could be done invite us to consider what policies might lead to improvements. Recent reports have emphasized the importance of focusing on system failure rather than practitioner failure to working to close these performance gaps. The United States has poured enormous resources into practitioner training and very little into improving processes in the systems within which those practitioners work, and it is time to redress that balance. Available evidence suggests that, at least for preventive services, systems changes are more effective than either provider or patient education in improving provision of services.”

*“Federal Agencies Don’t Provide Care. They can only provide technical assistance to practitioners, providers, and plans; take steps that will make it easier for practitioners and providers to deliver and for beneficiaries to receive needed care; and serve as conveners for partnerships among local stakeholders. Only practitioners and providers can make such systems changes as putting appropriate standing orders in place, installing failure-resistant information systems, and designing processes that deliver critical services within the optimum window of time. Segmenting improvement efforts according to payment source is inefficient and counterproductive. Partnerships among all of the stakeholders, regardless of source of payment, can make improvement possible and are urgently needed.”*



geographic location, benefit plan design, family composition (how many dependents are covered under a policy) and group size (how many employees a business has). By contrast, pure community rating allows no variation based on health status, age or sex. This was proposed in neither house during the budget process.”

**Myth: “Current Wisconsin law works fine; rates vary no more than 30% above or below a single midpoint rate, so the**

**premiums of any two small businesses don’t differ by more than 60%.** There is no such thing as a single midpoint rate, even for the same plan with the same carrier. The midpoint rate used in Wisconsin’s rate band law only applies to groups with identical group size, demographics (age/sex make-up of their workforces and single/family selection of each of their employees), occupations, and geographic locations. For two identical groups, rates cannot vary more than 30% above or below a midpoint rate, which is the arithmetic average of high and low allowable rates, but not necessarily the most-often-charged rate. If the budget were enacted as currently proposed, premiums for employees of two small Wisconsin businesses with the same benefit plan and same choice of single or family coverage would still be allowed to vary by as much as 800%.”

## Will Insurers Block Small Business Proposal?

Two years ago the legislature and then Governor Tommy Thompson recognized the need to create a small business health insurance purchasing pool. For it to have an opportunity to succeed, it is now clear that two additional steps are necessary. Assembly Bill 543 would create a startup loan for the program and restructuring of the rate band for the small business health insurance market. The insurance industry, opposed to losing a key competitive advantage by keeping the small employer market fragmented, has actively and knowingly spread “misinformation” about Wisconsin’s Private Employer Health Care Coverage Program. To set the record straight the following is from “MYTHS AND FACTS Relating to Small Employer Health Insurance Rating” prepared by the National Federation Of Independent Business, 9/01:

**Myth: “The current budget proposal amounts to ‘community rating.’** Fact: The current proposal only *reduces* the use of health status (medical underwriting) as a variable in setting health insurance premiums for small businesses. Health insurers would still be allowed to vary rates without limit using age, sex,

**Myth: “There’s no guarantee that this proposal will decrease rates.** Fact: That’s true, there is no guarantee that rates will decrease. But the proposal is consumer-friendly and addresses some of the biggest concerns of small businesses shopping for health insurance for their employees. Under the proposal, rate fluctuation based on medical underwriting would be limited. Small employers could then rely more on the accuracy of the rates they were initially quoted. This ‘truth in advertising’ would also improve small employers’ ability to compare health insurance options. Perhaps most importantly, more predictable health insurance costs would stabilize this growing portion of small employers’ bottom lines.”

**Myth: “Tightening Wisconsin’s rate band will cause health insurers to leave the small group market.** Fact: Contrary to what doubters predicted, in California

more health insurers entered the small-group market after rate bands were tightened to 10%; these insurers had not wanted to compete aggressively to avoid high-risk groups (as was required under the old system) and saw the change as leveling the playing field.”

**Myth: “8 out of 10’ small businesses, presumably those with low-to-average claims experience, will see dramatic rate hikes if the rate band is tightened.** Fact: Every small business is one claim away from becoming a high-cost group. There is no evidence to support the myth. The current budget proposal ensures that health insurance does what it is meant to do: spread the risk of high-cost medical care fairly across the broadest pool of enrollees. It is possible that low-risk groups will see a manageable, one-time increase when this change is first enacted, but over time, this tightening of the rate band will stabilize rates for *all* small employers.”

**Myth: “In a market with tighter rate bands, low-risk small employers will drop health insurance, causing premiums to rise for everyone who remains.** Fact: Nationally recognized researchers have watched for this phenomenon in several states that prohibit health rating (which is even more restrictive than the budget proposal) and this does not happen. Alternatively, if nothing is done, small employers facing high rate increases will increasingly shrink coverage offered to employees (by raising deductibles and copayments, for example) or drop coverage. In that case, their employees may turn to HIRSP, BadgerCare, and other public programs.”

**Myth: “All but one insurer left the market when Kentucky enacted community rating.** Fact: First, the statement at left applies to the *individual* health insurance market, not the small group market. As noted elsewhere, the budget proposal does not apply to the individual market. But even in the small group market, the current proposal is nowhere near as stringent as Kentucky’s small group reforms. Kentucky did not allow adjustments for health status or sex, and limited age variation to a 50% band; insurers were required to obtain State approval of rate increases of more than 3% above the consumer price index medical component before implementation; and the way in which Kentucky phased in its reforms created great difficulties for insurers. Research into the experience of Kentucky and other states has guided this proposal.”

**Myth: “Many other states are pulling back from their health reforms.** Fact: Despite continued pressure to loosen rating regulations, all but one state with rate bands or any form of community rating have not rolled back these reforms. A handful of states *are* modifying their small employer health insurance



regulations to address unintended consequences of their initial reforms (for example, the market disruptions caused by including ‘business groups of one,’ which act very differently and are not included in Wisconsin’s budget proposal). Even with these changes (only some of which are likely to be enacted), regulations in these states would be significantly more restrictive than the 10% rate band contained in the budget. The best lessons from all of these states are included in the proposal.”

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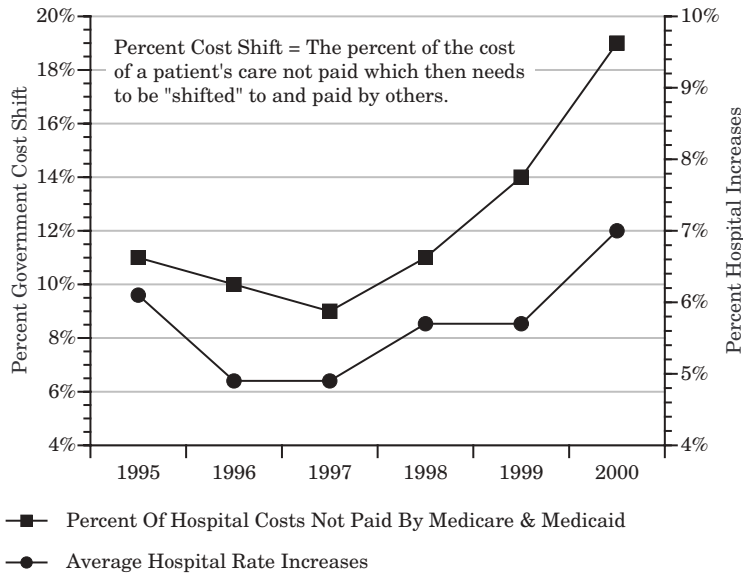
## Midwest, Medicare & HMOs

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From the “President’s Message” by Steve Brenton in the *Friday Mailing* of the Iowa Hospital Association, 10/05/01:

“In September, the American Hospital Association (AHA) made the appropriate decision to suspend advocacy activity related to pumping up Medicare payments to the nation’s hospitals. The decision, made in the wake of the tragic events of September 11, was predicated on the belief that Congress had lost interest in health care as a priority issue for the remainder of 2001. The consensus sentiment is that Capitol Hill efforts will emphasize the passage of appropriations bills with bipartisan support and that controversial and potentially expensive legislation, other than new spending for defense and security, will be held over until 2002.”

**Wisconsin Hospital Rate Increases Driven Up To Cover Increases In Government Cost Shift**



Data: Wisconsin Health & Hospital Association  
Wisconsin Bureau of Health Information  
Graph: RWHC, 9/01

**issue of enhancing Medicare HMO payments find an audience in Washington.”**

“The very notion that Medicare HMOs are about to be rewarded for dropping more than a half-million Medicare beneficiaries this year because of Medicare red ink is appalling. But the image of rewarding HMOs for behavior driven by profits while telling beleaguered community hospitals to ‘sit tight’ makes for a powerful message. And it’s a message that we will take to Washington if the opportunity emerges later this month.”

**Rural CEOs See Value Others Miss**

From “So, You Want To Be A Rural CEO. Why?” by Dave Carpenter in *Hospitals & Health Networks*, 6/01:”

“The hospital administrative jobs he'd held in Chicago, Detroit and the Boston area were interesting and paid well, yet a young and ambitious Terry Amstutz wanted something more. So he leaped at the chance to apply for a job that sounded ideal: chief executive officer of a small Arkansas hospital in the Ozark Mountains.”

“The AHA strategy, however, does acknowledge that the nation’s hospitals should be prepared to take advantage of ‘opportunities’ should they present themselves. And that may be about to happen.”

“In a late September press release, House Ways and Means Committee Chairman Bill Thomas (R-California) called for higher payments for Medicare HMOs this year, saying, ‘The current reimbursement formula fails to pay the true costs of health care’ and that legislation is needed to ‘entice these plans back into the program.’ In the same press release, House Health Subcommittee Chair Nancy Johnson (R-Connecticut) backed up Thomas.”

“Thomas’ position parallels recent statements made by Centers for Medicare and Medicaid Services (CMS) administrator Tom Scully, who is telling members of Congress they must change the formula by which health plans participating in Medicare+Choice are paid to cover the ‘rising costs of care.’ In fact, Scully claims to have convinced CEOs of unidentified HMOs to remain in the program for one more year by telling them Congress is likely to raise reimbursement rates by two percent and ‘loosen some regulations.’ ”

**“Community hospitals, especially community hospitals in upper Midwestern states that continue to face negative Medicare margins and equally laborious regulations, must be poised to enter the fray should the**

“To Amstutz, then 31, the appeal was obvious: a higher quality of life for his family, the camaraderie and teamwork of a small staff, a rural hospital’s huge impact on a community. But even his interviewers at Medical Center of Calico Rock (population 1,100) were skeptical. ‘They asked, ‘Why in the world would you want to move from a big city to here?’ ’ recalls the Pontiac, Ill., native. Eleven years later, Amstutz has no doubts he’s in the right place. ‘I don’t think there’s anytime I’ve regretted it,’ he says.”

“A lot of his small-town colleagues across the country share the sentiment. The difficulties that plague health care are only intensified for rural hospitals. Attracting medical and other staff is a challenge. Money to fix aging facilities is hard to come by. Keeping up with technology is a burden. Following regulations, especially unfunded mandates, is tougher than ever. Even so, many rural CEOs gladly forego the higher salaries and headier atmosphere that bigger organizations provide.”

“John Supplitt, director of the American Hospital Association’s section for small or rural hospitals, says the jobs are rich in certain intangibles. ‘The rural CEO’s profession is more of a ministry than any-

thing. It's their passion for the community's health and well-being that motivates them, not the pay.'"

**In The Public Eye**—"The need for versatility in fact extends far beyond the chief executive's desk. Hospital CEOs in every size market must maintain a public profile; for those in rural communities, where the hospital is often the biggest employer, the profile is magnified."

"Harvey Pettry, who heads Richland Memorial Hospital in Olney, Ill., has a good friend at a large hospital in St. Louis. While his friend meets only with business people, Pettry talks to church groups, attends weekend chowders in outlying communities and periodically invites area residents to group dinners. 'My friend's reaction is, 'Wow, that's way beyond my realm,' ' Pettry says."

"Rural CEOs say their accessibility is a plus but admit it does have drawbacks. 'It's rewarding in that whenever you take care of patients, they're your neighbors, your family, your friends, and you can make sure they've got the best care,' says Sullivan County's Gragg, CEO since 1997. 'When you go out, you know everybody and they know you. [But] it can be frustrating because people expect a lot. You're never really off the job, because at church or a ballgame people will ask questions.' Her peers agree. 'You don't leave your problems behind like you might when you leave your job at a city hospital and drive home to your suburb,' Pettry says. 'You live six blocks away and you run into those people wherever you go.' Personnel decisions can be most painful. Pettry had to cut his workforce by 33 people to make ends meet under the Balanced Budget Act, and then had awkward encounters with them and their relatives at every turn."

**Gone Fishing**—"However, rural CEOs insist the positive aspects of their jobs outweigh any drawbacks. Most rank quality of life as the No. 1 advantage. Take Ed Mahn, CEO of Ketchikan (Alaska) General Hospital, who revels in his environs on Revillagigedo Island. 'I've got pressures like anybody else, because I have to do with a lot fewer resources,' he says. 'But when I finish work at 5 or 6 o'clock I can jump in my boat and in five minutes be off anywhere fishing.'"

"When Calico Rock officials questioned his proposed Boston-to-Arkansas move, Amstutz had a ready comeback: His commute over three freeways took up to an hour and a half, the local water supply was unsafe, home prices were sky-high and there were break-ins in his neighborhood. 'I asked them how much of that they thought I was going to miss,' he says. Today his children play in the nearby woods and creek, his

## RWHC Eye On Health



"Yea, well my hospital is bigger than yours."

commute is five minutes, he owns a spacious home and he knows all his neighbors."

**Personal Connections**—"The bottom line for many rural CEOs speaks to why they chose the health care field to begin with. Bob Harman of 56-bed Grant Memorial Hospital in Petersburg, W. Va., can reel off a familiar litany of current hospital woes: shrinking resources, drastically reduced Medicare and Medicaid reimbursements, staff shortages, recruiting difficulties, the ever-increasing number of regulations and the painful impact of a struggling economy. He says that maintaining financial viability is harder now than during most of his 36 years at the facility. But his voice brightens when he talks about the patients. 'It's kind of neat to be able to relate to people and patients the way you can in a small place like this,' says Harman, 62, a local native. 'You have a greater ability to be closer to patients than in a large community.'"

"Ketchikan's Mahn echoes that, even as he dodges funding pressures or tries to recruit staff to a place that averages 156 inches of rain a year. 'I get instant gratification from the patients,' he says. 'My door's always open, and they come into the office and tell you how well they were treated. It makes you feel great.' Elderly patients often give Ormond jars of homemade jelly and bushels of tomatoes from their gardens to show their appreciation after hospital stays."

“It goes both ways. When an ice storm hit in December, staff at the Medical Center of Calico Rock remembered a patient who was diabetic. The nursing director braved treacherous roads, assisted by the sheriff, to reach the woman's remote home. She was running out of medicine, nearly in a coma, and might have died if they hadn't thought about her, Amstutz says.”

“ ‘We're never going to be rich,’ says Ron Butler, CEO of Laurel Health Systems in Wellsboro, Pa., which oversees Soldiers and Sailors Memorial Hospital. ‘We're never going to be at the point where we can relax, because you just get one problem solved and there's always going to be another one facing you. But to me it's worth it.’ ”

**Participants Sought For  
RWHC Virtual Private Network Pilot**

Over the past six months, RWHC has studied the feasibility of implementing a virtual private network. A VPN is a shared electronic network that allows users to exchange information and data less expensively and more securely over the Internet. This project was made possible by a grant from The Academy of Health Services Research & Health Policy in Washington, D.C.. A copy of the Feasibility And Design Study is available at the RWHC web site. Whether or not you are a RWHC member, if you are a rural hospital in Wisconsin and would like to be part of the pilot, contact Larry Clifford at RWHC (lclifford@rwhc.com).

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**Michael Decker Wins ACHE-WI Honors**

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The American College of Healthcare Executives Wisconsin Regent's Council has selected Michael Decker as the recipient of the 2001 Young Healthcare Executive Award. This award recognizes a College affiliate under the age of 40 who has shown exceptional leadership within his/her community.

Mike is president and chief executive officer of Divine Savior Healthcare in Portage, where he has been instrumental in successful strategic planning, physician recruitment, improving efficiency and economics through business development, marketing, team building and operations. He is active in the Wisconsin Health & Hospital Association and on the board of the Rural Wisconsin Health Cooperative.

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