Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – July 1st, 2003

Drive For Medicare Equity Has Deep Roots

When you read this, or soon thereafter, a Medicare Prescription Drug bill with the largest single step in Medicare equity for rural communities will have hopefully passed the U.S. Senate and House and on its way to a successful Joint Conference Committee. First, thanks to those in Congress who understand the importance of this issue and took action on that understanding. This seems an appropriate time to reflect on the history of the long rural struggle with this key issue. The following is from "A Pause On The Road To Rural Hospital Equity" in the Oct-Dec 1992 newsletter of the National Rural Health Association:

" 'The less things change, the more they remain the same'-Sicilian proverb.—This year (1992) has seen a number of important congressional, administrative and judicial events related to rural hospitals' quest for payment equity under Medicare's Prospective Payment System (PPS). While the backlash against rural hospitals implicit in some of these actions must be sobering, it is important that we maintain and assure a longer term perspective."

"During February of 1985, the second year of PPS, 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 (NRHA) first opportunity to present a rural perspective that seemed all but absent from the initial design. On behalf of the NRHA and Rural Wisconsin Hospital Cooperative (RWHC), testimony was presented 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.' NRHA 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.' Weeks later, Carolyne Davis, then head of HCFA, stated that they would answer questions about rural wages by the end of the year. Unfortunately basic questions re equitable area wage designations remain unanswered; if anything they are now more divisive."

"The complexity of PPS and the general lack of availability of wage adjusted national data have always made it difficult to get your arms around the equity issue difficult."

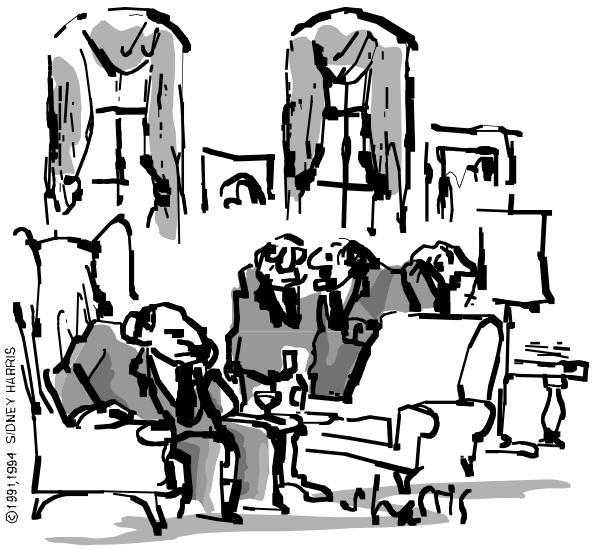
"To deal with this problem, the Rural Wisconsin Health Cooperative in Sauk City has found the comparison of 'rural Wisconsin' to 'Madison,

> "Mr. President, the rural health care safety net is coming apart. Our bill begins to mend it. Hospitals and home health agencies in rural areas lose money on every Medicare patient they see. Rural physicians are penalized by bureaucratic formulas that reduce payments below those of their urban counterparts for the same service. Our bill takes historic steps toward correcting geographic disparities that penalize rural health care providers… **I will insist that our rural policies be conferenced first."** *June 17, 2003 Opening Floor Statement of U.S. Sen. Chuck Grassley, of Iowa, Chairman, Senate Committee on Finance regarding the Prescription Drug and Medicare Improvement Act of 2003*

Wisconsin' a reasonable proxy for wage adjusted national comparisons. In PPS Year 2, hospitals in Madison, Wisconsin had a standardized base payment rate (controlling for case mix) 25 percent greater than rural Wisconsin counties and after applying the wage index, a differential of nearly 50 percent. Eight years later, in PPS Year 10, hospitals in Madison, Wisconsin have a standardized base payment rate only 4 percent greater than rural Wisconsin counties but after applying the wage index, a wage adjusted differential continues of nearly 20 percent. Those rural hospitals that were able to be reclassified by the Medicare Geographic Classification Review Board (MGCRB) into the Madison labor market have a wage adjusted differential reduced to 8 percent."

"Rural hospitals have made substantial progress towards equity. The improvements that have taken place are the result of both creative adaptations by rural providers and national initiatives to improve the equity of PPS payment formulas. Of greatest importance have been the Omnibus Reconciliation Acts of 1989 and 1990 with their commitment to phase out the urban/rural differential in the standardized base payment rate, creation of the MGCRB, improvements to expand the number of rural Disproportionate Share Hospitals, improved payments for Sole Community Providers and recognition of the special needs of small rural Medicare-dependent hospitals. But greater equity now also includes the reality that both urban and rural hospitals have on average significantly negative PPS operating margins. The aggregate PPS operating margin for all hospitals during PPS Year 9 is estimated by the Prospective Payment Assessment Commission (ProPAC) to be an average loss of 10 percent."

RWHC Eye On Health



"He is reminiscing about the good old days when the rurals knew their place and kept quiet."

"Underlying these many changes has been a broad acceptance of the idea that the initial design of PPS was particularly flawed as it negatively impacted on rural hospitals in ways that made neither professional nor political sense. But the wage bias has been particularly intransigent. From its inception, PPS has been biased against rural hospitals, in large part, through misunderstanding and manipulation of the model used to describe each hospital's relevant labor markets:

- In reality, professional markets now vary little over large areas of a state and variations in non-professional labor markets can be best visualized as gently rolling hills. I.e. wages change slowly over a region, not dropping abruptly at the county line.

- Professional labor shortages in rural areas have put a disproportionate upward pressure on rural salaries bringing them much closer to what had been higher urban salaries; an additional cost to rural hospitals not reflected in wage indices calculated using old and non-representative data of hospital expenses.

- Rural hospitals adversely effected by earlier PPS inequities have not been able to spend money that they did not have; the salaries of the employees of

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.

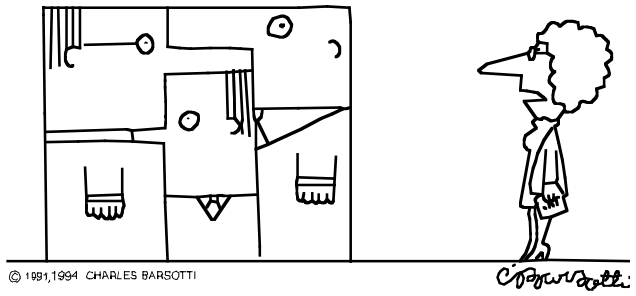
Eye On Health Editor: Tim Size, RWHC
880 Independence Lane, PO Box 490
Sauk City, WI 53583
(T) 608-643-2343 (F) 608-643-4936
Email: office@rwhc.com
Home page: www.rwhc.com

For a free electronic subscription, send us an email with "subscribe" on the subject line.

these hospitals have been artificially suppressed. Historical expense data for these facilities is a particularly poor proxy for local labor markets."

"In November 1987, the NRHA Board agreed to sponsor a class action suit against the Department of Health and Human Services (DHHS) and in November of 1988, filed its initial complaint in the United States District Court in Washington, D.C. The basic claim was that the relatively lower PPS payment rates for rural hospitals constituted a 'taking without just compensation,' a violation of the Due Process guarantee of the Fifth Amendment to the Constitution by unconstitutionally burdening a class of rural hospitals with the cost of subsidizing Medicare operations at their respective hospitals. The predicted response by DHHS was not to argue the case on its merits but to fight on jurisdictional grounds - that the Provider Review Reimbursement Board (PRRB) was the proper place to take this type of grievance. (Not part of the DHHS brief was the note that appeals to PRRB rarely if ever again see the light of day)."

RWHC Eye On Health



"Are you open to a new partner?"

"Oral arguments on the issue of the court's jurisdiction were heard on May 8th, 1989. Three and a half years later, NRHA has been notified that the Judge is accepting the Government's argument that his court does not have jurisdiction. While rural hospitals did not get their day in court for a 'constitutional challenge,' we believe that the credible pursuit by NRHA of this judicial remedy played a significant role in focusing attention on the seriousness of the structural defects in PPS and the need for Congressional action."

"During a part of 1992, our progress forward has been paused but it is now time to move on. We can not be distracted from our long term goals by either failure or half-victories. Max Depree in his new book Leadership Jazz says it very well: 'Fragility is part of a vision's nature. People who think they have created an indestructible vision simply issue a command, write an agenda. Had Odysseus sailed home according to an agenda, the account of his voyage would not be worth remembering.' "

Evolving The Rural Safety Net Strategy

From "A Health Care Safety Net for Rural America" in The National Conference of State Legislature's newletter, *State Health Notes*, 5/19/03:

"In rural America, there is often no publicly subsidized health care safety net for those who need it. Instead, a study of seven small-town communities published in the Spring 2003 *Journal of Rural Health* found, the safety net-'if there is one-is composed of private primary care practices and, in a few towns, a free clinic.' But how strong is that 'informal safety net' and should states and the federal government consider directing subsidies to the doctors who care for residents with 'inadequate health insurance,' defined to include both the uninsured and underinsured?"

"That's what a pilot project, jointly undertaken by the federal Office of Rural Health Policy (ORHP) and the rural health services research centers at the Universities of Minnesota, North Carolina at Chapel Hill, Southern Maine and Washington, set out to determine. In all, researchers examined primary care access in seven communities: two each in Maine and Minnesota and one each in Alaska, Idaho and North Carolina. To qualify, the sites had to 1) be a primary care service area (i.e., the next-nearest town with a primary care practice had to be at least 30 minutes/30 miles distant) and have 2) a population under 5,000; 3) at least two full-time equivalent primary care physicians; 4) no primary care practice receiving a public subsidy to provide safety-net care; 5) no more than one hospital; and 6) poverty/uninsurance rates at least equal to the state average."

"At the heart of the informal primary care safety net, it found, were 'private professionals and organizations that provide free or low-cost care to people unable to pay [and] that do not receive any public funds or other public support to compensate them for the services.' "

Questions And Answers

*"**What percentage of local residents need access to safety-net primary care?*** While definitive data were hard to come by, the study found that 'a substantial percentage' of the population in each of the areas had either no health insurance at all or were underinsured-that is, they had coverage but with high deductibles relative to their income. In 1999, for instance, the mean deductible for rural workers with family indemnity coverage was $1,000, compared to $500 for workers in urban areas."

"***What is the role of local public officials in ensuring access?*** Based on interviews with elected office holders or other key public officials in the study sites, researchers determined that in only two of the seven communities was government active in creating and maintaining a health care safety net. In the other five, officials 'did not perceive ensuring safety-net access as part of their official responsibilities or take part in any safety-net development activities,' leaving those roles instead to the private primary care practices."

"***Are those in need of safety-net primary care able to get it at private practices?*** Despite the small numbers, however, the answer to the question 'is a qualified yes' in six of the seven towns. In those six communities, the practices said they believed in providing care to all who sought it, and reports suggest they did so, even knowing that many patients would be unable to pay. The exception was the North Carolina site-a county of 12,000-where the one primary care practice saw only insured patients and inadequately insured patients who could pay cash."

"***How much safety-net care do the private primary care practices provide?*** Most practices didn't track uncompensated care amounts, making it hard to put a number to the total."

"What is the financial impact on the private practices of providing safety net care? Again, hard to gauge, though as the study said, giving away 5-10 percent of all services when the other 90-95 percent are reasonably well reimbursed 'is one matter. It is quite another matter when reimbursement is poor or barely adequate for a substantial percentage of services.' Unlike their urban counterparts, for example, rural practices cannot refer uninsured and Medicaid-insured patients to publicly subsidized practices, and they appear to receive a greater share of their revenues from Medicare, which is considered only an adequate payer."

"Eleven of the 15 practices were subsidized in other ways, however. Five were owned by a local hospital or regional hospital network, meaning their physicians were salaried, and two of the five were federally certified rural health clinics, meaning that Medicaid and Medicare paid the full cost of care. In addition, three of the solo practices in Idaho were indirectly subsidized by the county-owned hospital through things such as low rent in hospital-owned medical buildings."

Public Support

"The message to policymakers, said study coauthor Pat Taylor, who formerly served as director of research at ORHP, is that government needs 'to develop a means for subsidizing private primary care clinics,' in order to make certain that the uninsured and underinsured continue to get care in their community and that the practices can stay open. That needn't be a 100 percent subsidy, she added, but perhaps a tax credit that generates enough money to provide partial support for a sliding fee scale. Another option is for the community health center (CHC) program to contract with critical access hospitals in small, rural towns and rural health clinics to deliver the care, in effect redirecting part of its budget to providers who are already in place. 'In some little towns, there's enough primary care capacity, but it's hard for the practice to make it

Rural Health: Your Community Partner

View and use this eight minute video produced by the Northern Sierra Rural Health Network with support from The California Endowment. The video discusses the following key issues:

- The value of local health care.
- The economic value of rural health facilities.
- The importance of collaboration and partnerships.
- What local residents can do to support rural health care organizations.

A Downloadable Video and Program Discussion Guide are available on-line at www.nsrhn.org.

financially,' she said. Many of the doctors now providing free care in rural shortage areas 'would be delighted to get 50 percent of their costs.' "

RWHC Quality Improvement Capacity Model

As previously reported, fifteen RWHC hospitals have committed to a project entitled "Measuring Local Maternity Outcomes And Developing Capacity for Improvement" with financial support from the Madison—based Alliance Provider Quality Investment Fund. The following is a brief update:

The specific goals of this project were to 1) reach consensus on a common set of maternity care quality measures to allow for benchmarking among participants and the opportunity to identify best practices; 2) determine through chart review the degree to which each hospital is currently achieving those targets; and 3) to formulate specific quality improvement strategies based on the results.

This project was based on two premises: (1) that quality improvement is a continuous opportunity and challenge and (2) that extracting data for external organizations typically raises more questions than answers, so hospital staff members respond by attempting to drill deeper into a specific process or procedure.

The goal of this project was to have participating hospitals identify specific opportunities for improvement in their local maternity care, based on objective clinical measures and to establish the capacity to move forward with the appropriate interventions.

This project received external expert consultation from the following: Dr. William Hueston, a member on the NCQA/AMA/JCAHO collaborative panel to examine health quality for maternity and newborn care, Patricia Stone, PhD, MPH, RN, a AHRQ patient safety researcher, Dr. Susan Davidson, Director of Perinatology at St. Marys Hospital Medical Center in Madison, and Sherry Matson, a registered nurse, with eighteen years of OB experience served as the Data Abstractor.

Participants developed a list of eight measures, which were priority ranked by the participants. It was agreed that the top three measures would be used for the project, as well as one baseline measure that could be used for future quality improvement monitoring. The top three measures and the baseline measure were refined and reviewed by participating physicians and hospitals. The measures were as follows:

- Cesarean sections for dystocia
- Induction of labor for approved indications
- Symptomatic post-partum hemorrhage
- Appropriate pre-delivery management of Group B streptococcal colonized women (Baseline)

A listing of patient charts meeting indicator requirements within the established timeframe for the project was created by each hospital. This listing was sent to RWHC for random computerized sampling. For each indicator, the target sample size was 30 women from each hospital. Charts were pulled by hospital staff and reviewed by the nurse abstractor who was on site at each hospital for the review. Hospital staff were available to orient the abstractor to the chart and answer any questions that arose.

The community rate for unplanned cesarean sections was 12% with national data at 25%. The mean for inductions was 24% with Wisconsin's overall rate at 42%. Only 12 women (3%) from a sample of 436 experienced a hemorrhage that produced symptoms. Results indicate that participating hospitals are doing well with the treatment of women testing positive for Strep B. Each hospital received individual results and identified opportunities for improvement.

Lessons Learned

Active participation in all phases of the project, but especially for the development of the indicators was very time consuming, however critical to the success of the project. Significant time was spent with hospital staff, physicians and the project consultants discussing possible clinical indicators, indicator design, and data collection. These discussions created momentum for the project and built consensus for the indicators. They also provided opportunities for consultants and hospitals to share best practices.

Medical chart abstraction provided credibility to the project. A nurse with clinical experience relevant to the indicators performed the chart review at all hospi-

tals. This process also eliminated common problems with inconsistent data abstraction. Participants felt strongly that the chart review provided them with the most accurate clinical data, and thus more accurate reflection of the care provided. This level of credibility helped focus attention on interventions and allowed hospitals to specifically review pertinent charts.

Networking of participants added much depth to the project. The opportunity to discuss issues, share ideas, talk through challenges and possible interventions created final products, i.e., measures and interventions of a much higher caliber than could have been developed by individuals working in isolation at each hospital. Throughout all of this was a thread of education that was equally important.

The "cast of characters" was also vital to the success of the project. Local physicians also provided valuable insight in practice issues and were especially helpful in the intervention discussions. The physician consultant was able to provide the medical perspective and create a more blunt discussion than may occur in the individual physician-nurse interaction. The majority of the hospital representatives consisted of OB nurses and quality coordinators bringing the data and day-to-day reality perspectives to the table.

Next Steps

After presentation of the data, hospitals identified specific improvement activities based on their individual reports. These activities include stratifying charts for reasons for cesarean sections; conduct chart review of symptomatic post-partum hemorrhage to identify trends such as physician practice patterns, delivery type, and interventions utilized; increase use of internal uterine monitors to document adequacy of contraction pattern prior to proceeding to cesarean section for dystocia; look at cesarean section rates as it relates to use of epidurals; and make documentation recommendations that would more accurately reflect the care given and result in more accurate coding. Several improvement opportunities were also identified that lend themselves to a collaborative effort for benchmarking additional data and using economies of scale.

At the request of the participants, a measure for Group B Strep will be developed and added to the RWHC Quality Indicator Program non-core measure set. This will allow ongoing monitoring of best practices related to identification and screening of Group B Strep, specifically related to the August 2002 CDC Guidelines. Monitoring activities will occur via the RWHC Quality Indicator Program participants and the RWHC Quality Coordinators and OB Roundtables.

The data abstractor also shared related observations and provided education to the RWHC HIM Coding Consultant, the RWHC Coding Roundtable, and is planning to meet with the RWHC OB Roundtable. These discussions may identify and provide a forum for further improvement opportunities.

Dietary Past Part Of Today's Health Crisis

From "U.S. Society Needs Radical Reform Of Dietary Habits" By John Hansen in the *Wisconsin State Journal,* 6/21/03:

"There has been an insidious change in human behavior related to food and exercise in the last several hundred years. We know from anthropological research our human ancestors obtained food exclusively as hunter-gatherers for about five million years, eating fruits, vegetables, nuts, fish and some very lean meat from killed animals. The fat content of this food was exceedingly low, almost devoid of saturated fat."

"As our descendents began to settle into small communities to raise crops and herd animals about 13,000 years ago, food was still relatively simple, still very low in fat and still accompanied by strenuous physical activity."

"The advent of modern civilization changed our consumption of the type and content of food. The agricultural sciences introduced animal breeding to give higher fat marbling in beef and higher fat concentration in milk. The latter higher fat content allowed the production of butter, cheese, ice cream, cream cheese and sour cream, all of which have become substantial components of the average diet."

"The introduction of refined flour and sugar has resulted in a lower consumption of the important fiber

present in whole grains and a greater consumption of rapidly absorbed simple starches and sugar. In the past 100 years, partially hydrogenated oils have been used in the commercial production of most of our baked goods, resulting in high consumption of unhealthful trans-fatty acids. These dietary changes went hand-in-hand with a huge reduction in exercise by the average person as various forms of transportation reduced our need for physical exertion."

"There are individual and societal responsibilities imbedded in this problem. People make decisions every day about what they eat and whether they exercise. Society is complicit by providing easy, inexpensive access to unhealthy food to consumers lacking knowledge and information. Sadly, we are leading our children down the same path."

Doctor Smith Goes To Town Amazon Style

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. Donations are welcomed c/o: Amazon Medical Project, Inc., 106 Brodhead St., Mazomanie, WI 53560. AMP is a non-profit, tax-exempt organization.

"One day, I needed to go to the city, and it was a day when there were no fast boats leaving. ... well, there are always the *colectivos*, the 'river taxis' on which the local folks travel. So Kalindi and I opted for that."

"To do so, we rose early, and after doing a little fancy footwork to dodge the tapir, who had gone into heat and was not feeling kindly toward other females, we went in a light misty rain, to the clinic. There we made coffee and munched on the pastries that the cooks had given us until we heard the Clarita, one of the river taxis, pulling over to the island across from the clinic. From there, she would head to Armando's place, where we intended to board, so we polished off the coffee and rolls, collected our bags, and walked down to Armando's."

"It took forever for them to load all that was going to the city from the families on the island (mainly heavy bags of charcoal, destined to be used for cooking by people in the city who can't make open fires as we do in the rural areas, and equally heavy sacks of fruit). Then the boat made its way slowly across the river, and we climbed in through a window, since there was an obvious glut of people, sacks, and produce between the tiny door at the prow of the boat and the area where we could sit, and found seats on the planks along the walls, leaving Armando's dock at about 7:45 a.m. We made eight or ten stops between there and the tip of Yanamono Island (including one more on the island itself, zigzagging across the Amazon between the shore and the island)."

"We were sharing the boat with plastic tubs filled with *aji*, the local hot peppers, and with tomatoes, sweet finger-size bananas, *cocona* (a tomato-like fruit), sweet peppers, cucumbers, passion fruits, palm fruits, peanuts, *juanis de yuca* (little packets of boiled and mashed cassava root, patted into rectangles and filled with a few bits of meat and vegetables, then wrapped in leaves and sold to the boat's passengers as breakfast), and with *bijau* leaves, used to wrap the *juanis* and destined for the markets of Iquitos, like all the rest of the produce in the boat."

"Then there were baskets and buckets and crates stuffed with papaya and grapefruit and heaven knows what else; and eight or ten chickens perched nervously on the window edges, each with a little strip of vine around its leg to keep it from flying off in a panic; and there were two hammocks slung crossways and about 25 passengers, and up in the prow, just below the front door, a not-quite-grown pig and a small goat. A medium-sized *dorado*, the large catfish that comprise a goodly part of the diet here, lay on the floor a little aft of us, and there were many huge bunches of plantains (they look like large green bananas but are for cooking, not sweet for eating raw). There were also an inordinate number of *mantablanca*, little noseeums flies whose nibblings kept us scratching at elbows and moving our feet."

"All this was inside the boat, which was maybe eight feet across, forty or fifty feet long, with a low flat ceiling overhead."

"Up on the roof were piled the bags of charcoal, more bunches of plantains, several empty 55 gallon drums (no gas stations in the rainforest, so those who have chain saws or other equipment have to bring gas from Iquitos), the six-foot-long bench loaded at Nuevo Sinai, some bundles of firewood, and another dozen or so travelers. Odilio, the owner, stood on the prow, his head and shoulders out of sight above the low roof but his hand down at his side and visible through the doorway, signaling to his son Coco who was sitting in the very back of the boat with a pair of Yamaha 75 hp outboard motors, driving. Odilio's hand motioned gently: slow down, pull right, hold steady, go on, etc."

"The rest of the crew were two or three lean but sinewy young men clad in ragged shorts, shirtless and barefoot, who leaped ashore at each stop and loaded the heavy bags of produce onto the boat. They were pretty skinny overall but with well-developed shoulders, arms, backs and legs, and impressive balance ... when loading at Nuevo Sinai, they were climbing (barefoot, of course) up and down steps cut out of the muddy bank with a machete, carrying all those bulging and weighty sacks on each trip down the slippery slope. From the riverbank they stepped into a loosely tethered dugout canoe with one foot, then over into another canoe with the other foot, then reached across a foot or two of open water to hand their loads off to Coco, who stored them inside the crowded boat."

"Once past Pucalpa, halfway to Indiana, it was relatively smooth sailing, with only a couple of stops, so Odilio left his post at the prow and walked back over the roof and down a little ladder into the boat's interior to talk a moment with Coco. As he was about to go back up, I stood and leaned over to ask him, above the roar of the motors, how much we owed for the passage. He smiled and shook his head and said *nada* (nothing) – you have helped my family many times, he said; I am happy to give you passage. I smiled back and gave him a quick peck on the cheek, and laughter rippled through the vessel's occupants."

RWHC's Eleventh $1,000 Hermes Monato Rural Essay Prize—The 2003 Prize has been awarded for "Living Histories: Wisconsin's Rural Physicians of the 20th Century" by Amy Schnettler, now a third year student at the UW Madison School of Medicine.

Space Intentionally Left Blank For Mailing