

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

A Vision for the Future of Rural Health?

The Institute of Medicine (IOM) is best known to many through its 2000 report on patient safety, "To Err Is Human." The report is widely credited with launching the current "revolution" in quality improvement and public accountability. IOM has now agreed to study rural health with a project entitled, "Building a 21st Century Community Health Care System in Rural America." The following is from the IOM web site and private correspondence:

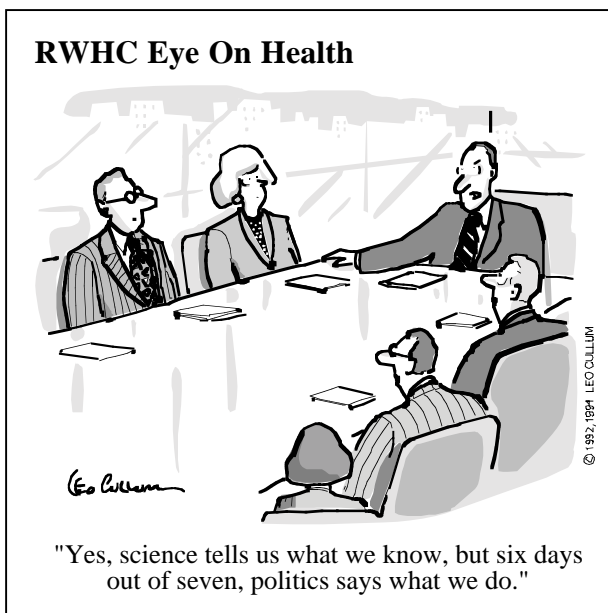
"The Office of Rural Health Policy, Department of Health and Human Services has requested that the Institute of Medicine establish a committee to provide an independent, unbiased assessment of the quality of health care in rural America. The committee will develop a conceptual framework for a core set of services and the essential infrastructure necessary to deliver those services to rural communities. The committee will also recommend priority objectives, identify the changes in policies and programs including, but not limited to, payment policies and the necessary information and communication technology infrastructure needed to advance the identified objectives. In the entire analysis, the committee will consider implications for federal programs and policy. The study will make recommendations on an agenda for

quality improvement in rural settings, identifying the performance characteristics that model 21st century community rural health systems should meet."

"As a major part of the study the committee will convene a large day-and-a-half workshop in addition to three committee meetings. The discussions at the workshop will focus on the key characteristics that are unique to rural environments and map out the characteristics that a model rural community health system should meet in terms of care delivery, payment, quality monitoring, reporting, IT infrastructure, and other relevant areas."

The Committee's work is funded by the Federal Office of Rural Health Policy within the Health Resources & Services Administration and by the W.K. Kellogg Foundation.

Frequently Asked Questions about IOM



"Is IOM part of the government or quasi-government? Who does IOM work for; where does your funding come from?" The National Academy of Sciences was created by the federal government to be an adviser on scientific and technological matters. However, the Academy and its associated organizations (e.g., the Institute of Medicine) are private, non-governmental, organizations and do not receive direct federal appropriations for their work. Studies un-

dertaken for the government by the Academy complex usually are funded out of appropriations made available to federal agencies.”

“**What is unique about IOM?** The congressional charter mentioned above places the IOM in a unique role. Beyond that, the IOM process establishes it as an independent body, with its use of unpaid volunteer experts who author most reports. Each report must go through the IOM/NRC institutional process, assuring a rigorous and formal peer review process, a requirement that findings and recommendations be evidence-based whenever possible and noted as expert opinion where that is not possible. The committee may deliberate among themselves, and is not obligated to conduct all their work in a public forum.”

“**What is the role of the committee?** Committees are the deliberating and authoring bodies for IOM reports, although strict institutional processes must be followed and the peer review process is independent of the committee. Most committees are consensus committees, meaning the process is designed to reach consensus on the evidence base and its implications.”

The Committee will first meet in late September and is expected to deliver its report by July 31st, 2004, which will include: (1) committee’s discussion of the findings, conclusions and recommendations based on the evidence gained; (2) synthesis of the workshop discussions; and (3) commissioned papers, as appropriate. The Committee roster includes:

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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We Can’t Improve What We Don’t See

From “Out of Sight, Out of Mind: Why Doesn’t Widespread Clinical Quality Failure Command Our Attention? Can health industry leaders sustain a focus on problems that inherently resist visibility?” by Arnold Milstein and Nancy E. Adler in *Health Affairs*, March/April, 2003:

“This paper examines the tolerance by all stakeholders of increasingly well documented evidence of serious

and widespread clinical quality failure in the United States. Using research evidence from psychology, it describes specific cognitive and motivational impediments to the perception of quality failure—those shared by all stakeholders and those particularly relevant to patients and their families and to health care professionals. The authors endorse efforts by the National Quality Forum and others to make quality failure more publicly visible. They also point to the pivotal role of health care industry leaders in sustaining focus on a problem that inherently resists visibility.”

“Since 1998 the Institute of Medicine (IOM) and other credible sources have reported widespread and serious health care quality defects occurring even in our best delivery systems. The resulting toll in avoidable human suffering and wasted resources is high. An average American’s combined exposure to quality failure from providers’ underuse, overuse, and misuse of services is roughly 50 percent for preventive, acute, and chronic care services. Although the recent alarm sounded by the IOM has captured temporary media attention, tangible corrective actions have been modest relative to the size of the problem.”

“Such passivity is striking. Americans generally insist on rapid corrective action when operational failures in major industries lead to high rates of injury or death. Why don’t widespread clinical quality problems in health care elicit a similar response? While perception of a serious problem is not sufficient to assure robust corrective action, it is an essential first step. Since some impediments to perception are shared by most stakeholders while others are more significant for patients or health care professionals, our discussion organizes the impediments in these three categories.”

“The array and strength of both universal and role-specific impediments to detection of quality failure are sobering. Most physicians and consumers estimate error-mediated health care deaths at less than one-tenth of the mid-point of the IOM’s estimated

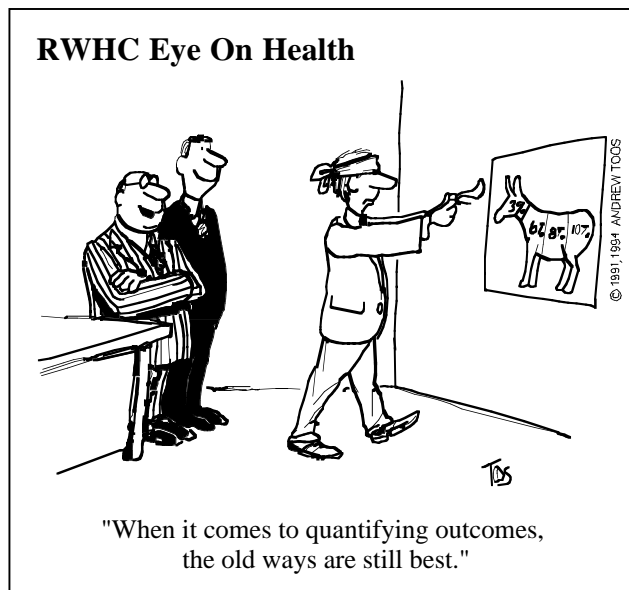
range. When considered together with the large magnitude of quality failure and our collective tepid response to the IOM’s unambiguous alarms, these impediments constitute a strong rationale for vigorous policy intervention to strengthen detection and correction of health care quality failure. Cognitive and motivational impediments to accurately detecting quality failure make it highly unlikely that appropriately vigorous corrective action will naturally occur. Knowledge of these impediments can guide specific remedies to reduce their impact.”

“The National Quality Forum Strategic Framework Board’s recommended approach to engaging consumers in quality-based decision-making and implementation tools from the Foundation for Accountability constitute thoughtful guidance on how to expand public awareness. Health care professionals, the media, accreditation groups, and government are likely to be sensitive to consumer pressure for quality reform.”

“Exhibit 1 summarizes current approaches addressing each impediment; it also suggests associated gaps that require new policy solutions. It will be difficult to mobilize a critical mass of discerning consumers. As a result, robust problem correction, including necessary measurement systems and fundamental changes in health care

industry work methods, may not be adequately rewarded in the market. Accordingly, much will pivot on the vision and ethics of private- and public-sector leaders. The initiation of the National Quality Forum to create universally visible, provider-specific measures of quality is tangible evidence of such leadership. So is the formation of the Leapfrog Group to publicly identify and reward provider breakthroughs in patient safety. Several provider trade association, foundation, accreditor, and government initiatives to speed and publicly document progress toward greater quality reliability have begun.”

“However, the very low natural rate of signal detection explains why major reduction in clinical failure will



Current Approaches To Address Perceptual Impediments To Quality Improvement

From “Out of Sight, Out of Mind” by Arnold Milstein and Nancy E. Adler in *Health Affairs*, March/April, 2003

Perceptual impediment	Current approaches	Gaps in remedies
Universal Impediments		
Availability heuristic (a heuristic serves as a guide in the investigation of a problem)	Some efforts to alert all stakeholders to overall magnitude of peril from quality flaws	Most awareness-raising efforts fail to use compelling, tangible images and stories comparable to anti-tobacco efforts
Familiarity heuristic	NQF, NCQA, JCAHO, CMS, Leapfrog, and commercial efforts to standardize quality ratings for individual providers	Slow progress, absence of cross-cutting performance measures, under-investment in measures development and electronic clinical information systems
Optimistic bias	Some efforts to alert clinicians and patients to personally relevant quality risk	Educational efforts fail to convey that danger exists even among best providers and that multilateral quality vigilance is integral to excellent health care
Dissonance reduction	None explicit	Educational efforts fail to convey that danger exists even among best providers and that multilateral quality vigilance is integral to excellent health care
Discounting principle	Increase root-cause analysis, share results with patients and families	Actual implementation spotty and mostly confined to serious adverse outcomes in hospitals
Fundamental attribution error	IOM reports clarifying that most flaws originate in faulty systems of work, rather than individual negligence	Malpractice liability, mainstream attitudes, and hospital policies remain focused on individual negligence
Patient-specific impediments		
Simplicity bias	Some performance ratings and self-help messages are concrete and presented in easily interpretable summary form	Insufficient availability of summary performance measures or decision-support software to reduce analytic burden
Authority bias	Pilot projects in shared decision making	Expert physician visibility in quality guidance programs insufficient to compete for patients’ trust
Reduced critical faculties	Medical conservatorship by families for extremely impaired patients; some hospitals and insurers offer patient advocates	No programs to automatically provide patient advocate when patient’s or family’s analytic faculties are insufficient to judge quality
Clinician-specific impediments		
Wishful thinking	Widely subscribed, scientifically valid performance assessment and operational improvement systems exist for a few provider groups; some physicians obtain board recertification	Very few current services are subject to robust provider performance feedback; real-time error alerts, such as CPOE systems, are also very rare
Defensiveness	Blame-free error reporting in some institutions; positive results from early efforts at full disclosure of preventable adverse events	Few care systems have routinized blame-free reporting and remediation

hinge on whether health industry leaders are able to sustain a focus on problems that inherently resist visibility. Most people will be indifferent to a problem they cannot see. Will our leaders be adequately visionary?”

Focusing on Variation in Medical Practice

From “Findings from research by John Wennberg and colleagues at Dartmouth College concerning variation in service use” in MEDPAC’s *Report To Congress, Variation and Innovation in Medicare*, 6/03:

“Wennberg and Cooper find variation in Medicare expenditures (adjusted for input prices and health status) is affected by the supply of hospital beds, which varies considerably across areas. As the number of hospital beds per beneficiary increases, the amount of hospital care per beneficiary increases (Wennberg JE, Cooper MM. *The Dartmouth atlas of health care in the United States: a report on the Medicare program*. Chicago (IL), American Hospital Association Press. 1999).”

“Variation in expenditures is also affected by differences in rates of surgical procedures. The rates at which beneficiaries receive some surgical procedures—such as radical prostatectomy, carotid endarterectomy, coronary artery bypass grafting, and coronary angioplasty—are very different across areas. The rates of radical prostatectomy (surgery for prostate cancer) are nine times higher in Baton Rouge, Louisiana, than in Binghamton, New York. Wennberg and colleagues believe that much of this variation is reflected in differences in diagnostic intensity (how intensely physicians search for a condition that results in surgery). For example, patients in the early stage of prostate cancer are often asymptomatic, so diagnosis is often made through a screening test for prostate-specific antigen (PSA). The frequency of PSA testing varies greatly, so there is much variation in how frequently patients are diagnosed and, consequently, how often they undergo prostate surgery. Wennberg and colleagues also believe gaps in medical science as well as uncertainty physicians have about the benefits and problems as-

sociated with many procedures affect variation in surgical rates. They suggest that variation in radical prostatectomy, for example, may be due in part to a lack of clinical trials comparing the risks and benefits of surgery, radiation therapy, and watchful waiting (Wennberg and Cooper 1999).”

“Geographic differences in per beneficiary Medicare expenditures are highly correlated with differences in the amount of services beneficiaries receive in the last six months of life. Also, geographic differences in the amount of supply sensitive care (where the effectiveness has not been scientifically determined and use is largely driven by resource availability, such as number of hospital beds) strongly influences differences in the amount of care at the end of life. In particular, Wennberg and colleagues found large differences in the number of physician visits, likelihood of dying in a hospital, and the percentage of beneficiaries admitted to an intensive care unit at the end of life (Wennberg and Cooper 1999).”

“Fisher and colleagues examined differences in the services physicians furnish in high- and low-spending areas. They found that physicians’ greater use of evaluation and management services—especially inpatient visits and inpatient specialist consultation—and use of diagnostic tests and minor procedures, such as magnetic resonance imaging, skin biopsies, and prostate-specific antigen tests drive spending differences. As discussed, they have also found no correlation between higher use and quality of care (Fisher et al. 2003).”

The two hundred page report is available at:
www.medpac.gov/publications/

Jury Out on Consumer Driven Health Plans

From “Health Insurers Let Consumers Balance Costs” by Steven Findlay in the Forum, *USA TODAY*, 7/16/03:

“Like millions of Americans, Lora Biessenberger got her health insurance for years through an HMO of-

ferred by her employer, Louisiana State University. But last year, LSU, seeking to lower its health care costs, offered another choice, and Biessenberger decided to try it out.”

“Along with 6,700 other employees at LSU and 1.5 million people nationwide, Biessenberger is part of a massive experiment that could presage a significant shift in the health care landscape during the next decade.”

“Boiled to essence, employers and health insurers want you to pay more of the health care tab, or at least be at risk of paying more. While on the face of it that doesn’t sound like a good development, it actually may be – up to a point.”

“That’s because job-based health-insurance coverage (for those who have it) has expanded so much in the past 15 to 20 years that people have become somewhat blind to the real and persistently rising costs of care. If all you pay is a \$15 co-pay, for example, there’s little incentive not to go see a doctor. That generates more costs, such as additional tests.”

“The original idea was to reduce obstacles to seeing a doctor. But we may have overshot the mark. The result: We’ve become a nation of profligate, sometimes even gluttonous, medical consumers. As long as someone else is paying the bill, who cares? In other words, you and I are part of the problem of those inexorably rising health costs we hear so much about.”

“Americans in 2001 paid 14.4% of the nation’s \$1.4 trillion health care tab out of their own pockets, down from 20% in 1990, 24% in 1980, 34% in 1970 and 50% in 1960, according to government data. Half or a third is certainly too high, but 14% may be too low. This got employers, insurers and some entrepreneurial companies thinking: What if we give consumers a bit more ‘skin in the game’ and activate them to become discriminating, price-conscious medical consumers?”

“Enter Biessenberger, 40, a wife and mother of four. What she signed up for is being called a ‘consumer-driven’ health plan. It works like this: LSU and, in this case, plan manager Definity Health, give \$2,000 annually to her family. The money is in an account the family can use to pay allowable routine medical expenses.”

“If their expenses go above \$2,000, Biessenberger and her husband are on the hook for the next \$1,000 of care. After that, LSU and Definity pay 90% of all allowable medical expenses up to \$10,000 and 100% afterward. If the family spends less than \$2,000 in a given year, what’s left is rolled into the next year – and it gets another \$2,000. The family must exhaust that new total amount before any coverage at the 90% level kicks in. A maximum of \$4,000 can accumulate in the account.”

“Is this the magic bullet that will rein in health costs? Almost certainly not, though early evidence indicates some targets are being hit. For example, one study by a benefits consulting firm found that 835 families that switched to the new type of plan had 18% fewer physician office visits and their overall use of care was down 11%.”

“But there are potential dangers lurking in the design of these new plans that could limit their long-term viability and even harm some consumers. The major ones:

- They require consumers to become better at budgeting health care needs.
- They shift costs to the less healthy.
- They don’t really target high medical costs.
- They could induce people to skimp on needed care.”

“Consumer-driven health plans are a bold new idea. They will appeal to many and provide a critical test of whether shifting costs back to consumers will ease the health-cost spiral. But until the plans prove themselves, employers and consumers should be vigilant.”

Enough Already Re Liability Insurers

From “Doctors, hospitals form own insurance carriers to stabilize rising costs, Coverage rates for malpractice fuel changes” by Gideon Gil in the *The Courier-Journal*, 8/15/03:

“Fed up with soaring premiums for medical malpractice insurance, Kentucky physicians and hospitals are forming their own insurance companies.”

“The emergence of provider-owned, nonprofit insurers is not a new solution for high malpractice-insurance rates. The state medical and hospital associations formed similar provider-owned companies in the late 1970s during a previous crisis. But in the mid-1990s commercial insurers entered the market with cut-rate premiums, drawing away customers and eventually causing the companies to merge with out-of-state insurers.”

“The Kentucky Hospital Association announced this week that it has created a company owned by 21 small-to-medium rural hospitals that used to be insured by a financially troubled Virginia company, said Brian Brezosky, a senior vice president at the association.”

“ ‘These are hospitals in the state who have gone through a lot of pain,’ he said, noting that most of them have faced premium increases of 50 percent to 100 percent in each of the past two or three years.”

“The new company, Kentucky Hospital Insurance Co., is managed by a for-profit Kentucky Hospital Association subsidiary.”

“It will not necessarily save hospitals money on their premiums, but it will have more predictable rates and give hospitals greater control over management of the company, Brezosky said. ‘Our intent isn’t to have cheaper premiums,’ he said. ‘Our intent is to have a stabilized marketplace.’ ”

New Report on How Networks Add Value

From *Using Rural Networks to Address Local Needs, 5 Case Studies* by Ira Moscovice, Ph.D., and Walter Elias, Ph.D., 7/03:

“Networks bring together rural providers—and possibly other agencies, employers, or community organizations—to address health care problems that could not be solved by any single entity working alone. The aim of the Networking for Rural Health project, a recently completed three-year initiative of The Robert Wood Johnson Foundation, was to strengthen the rural health care infrastructure by fostering development of rural

health networks that seek to improve access to and the quality of health care services in rural communities.”

“The purpose of this monograph is to present five case studies of networks that used the resources provided by the Networking for Rural Health project to plan and implement activities to meet community needs. These case studies highlight a range of network sizes and compositions, service area characteristics, and relevant activities.”

“Each case study includes the network’s history and background, a description of the objective of the targeted consultation, and the progress the network has made in reaching their goals. The case studies also detail implementation challenges, post-grant activities, the potential for replicability, and lessons learned. We hope these case studies will interest rural health care leaders as they strive to improve their understanding of how the collaborative efforts can address local needs.”

The 44 page report is available on-line at:

www.academyhealth.org/ruralhealth/casestudies.pdf

Passion Is No Excuse for Political Excess

From “A Careless Season in American Politics” by George F. Will in *The Boston Globe*, 8/3/03:

“ ‘They were careless people, Tom and Daisy—they smashed up things and creatures and then retreated back into their money or their vast carelessness.’ F. Scott Fitzgerald ‘The Great Gatsby’ ”

“In this season of vast public carelessness, political Toms and Daisys are trashing civic life, making messes, and moving on. And there are no large ideas commensurate with and capable of at least explaining the institutional damage being done.”

“In Texas last week, Democratic legislators left the state for a second time in 11 weeks. They fled—this time to New Mexico; last time to Oklahoma—to prevent a legislative quorum. Republican legislators want to draw new legislative district lines for the second time since the 2000 Census, a mischievous idea already acted on by Colorado Republicans.”

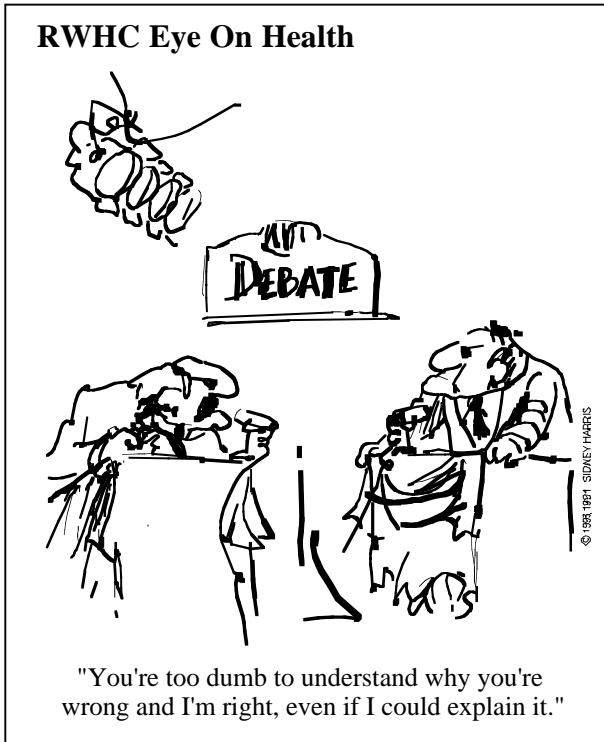
“This aggression—which Democrats will feel free to emulate when next they have a majority - shreds a settled practice that limits to once after each census the bruising business of seeking political advantage through redistricting. Defenders of the Republicans say they are breaking no law—that the once-a-decade practice is only a custom.”

“But many of the practices that reduce the friction of life are ‘only’ customs. And when the cake of custom crumbles it is replaced either by yet more laws codifying behavior that should be regulated by good manners or by a permanent increase in society’s level of ongoing aggression.”

“Political incivility feeds on itself. A dialectic of aggression and retaliation began

with the defeating in 1987 of the nomination of Robert Bork to the Supreme Court. Democrats established the principle that the custom of broad deference to presidential choices would be superseded by political tests of strength over nominees’ philosophies.”

“Life has been called a series of habits disturbed by a few thoughts. Civil society is kept civil by habits of restraint. Inflammatory political ideas can overturn habits, sometimes for the better, usually not. But no discernible ideas, at least none that are more than appetites tarted up as ideas, account for the vandalism by political over-reachers of both parties.”



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