Rural Wisconsin Health Cooperative

Serving rural communities for 25 Years 1979-2004

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2004

Metros Value FQHC Partnership—Rural Next?

From a description of the WHA Primary Care Access Initiative in Milwaukee County. For information contact Bill Bazan, VP, Metro Milwaukee, for WHA at 414-431-0105 or at <bbazan@mailbag.com>:

"The Wisconsin Hospital Association (WHA) in collaboration with the Wisconsin Primary Health Care Association (WPHCA) initiated a primary care access initiative in Milwaukee County aimed at providing more access points and primary care services, especially for the uninsured and Medicaid populations. Over the past 6 months, the 5 Healthcare Systems and the 4 Federally Qualified Health Care systems (FQHCs) in Milwaukee County have been in meetings with a consulting firm out of Washington, DC, to develop a conceptual and implementation plan for increasing primary care access and services in Milwaukee County."

"Availability of and access to comprehensive primary care for vulnerable populations, increasingly the uninsured, has been a long standing challenge and health care system delivery challenge in Milwaukee County. Congress and the federal Department of Health and Human Services, Health Resources and Services Administration (HRSA), have addressed this problem through the Public Health Service (PHS) Act, section 330, and the Federally Qualified Health Center Medicare and Medicaid legislation found in the Social Security Act and the National Health Service Corps (NHSC) federal legislation."

"Implementation of these federal initiatives includes federal criteria and designation of Medically Underserved Areas (MUAs) and Health Personnel Shortage Areas (HPSAs). When urban and rural areas across the country meet these criteria and are so designated, these areas become eligible for federal resources designed to address the development and enhancement of comprehensive primary care to increase access and services for vulnerable populations. FQHC Medicaid and Medicare provider status covers a mandatory bundle of services with special cost-based reimbursement. President Bush initiated a 5 year plan to double the number of community health centers in both rural and urban areas."

"The Primary Care Initiative Steering Committee in Milwaukee county, in the face of a crisis in primary care access, with rising numbers using hospital emergency departments as primary care clinics, and State and County budget deficits at hand, came together, put competitive issues aside, and began defining the problem in a true spirit of collaboration to seek coordinated solutions to increasing primary care access and services, reduce inappropriate emergency department usage and capitalize on federal opportunities."

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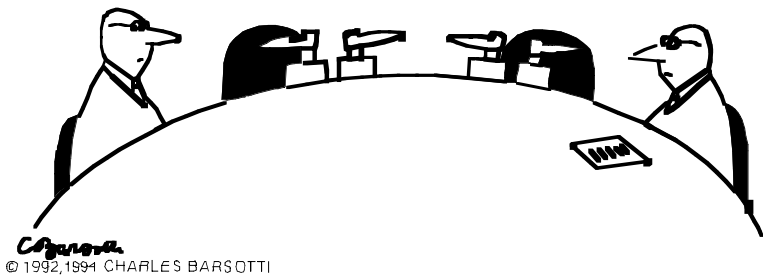

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"The collaboration makes sense, but it will take a while to understand them."

"An indulgence that alleviates stress is often a better choice than a sacrifice that creates tension." Habana Café, St. Petersburg, Florida

We Fail to Offer Kids Basic Dental Care

From a letter to Governor Jim Doyle from the Wisconsin Primary Health Care Association, 2/2/04:

"As you know, previous Administrations have sadly ignored the increasing problem of statewide dental access, particularly, a problem for the Medicaid/BadgerCare participants. The Association has engaged in meaningful discussions with the Department of Health and Family Services on the need for creative short-term and long-term strategies to address the dental access problem. We strongly urge you to continue steps to improving the significant statewide dental access problem. Policy actions you should consider include the following."

"Under the Medicaid program pay non-oral health providers for administering fluoride varnishes to children as key preventative action. This is a short-term and long-term solution because if it is a 'supply and demand' economic issue, then allowing other providers to take preventive oral health care steps for children will save money on long-term health costs due to unattended care."

"Make changes in the Dental Examining Board Licensure process. Wisconsin needs more dentists and the state should recognize a valid license and practice experience of oral health providers from other states."

"Expand scope of practice for dental hygienists. These important oral health professionals can assist in greater latitude of preventive oral health procedures."

"Create public health dental loans and scholarships. Dental students need to be encouraged about the personal and social value in practicing in underserved areas. Teaching a public health perspective at dental schools is critical. State dollars must be increased under the student loan forgiveness program for a new dentist agreeing to take a specific number of Medicaid patients. A specific scholarship program could require a longer period of service in an underserved area and require serving a number of Medicaid patients."

"Tie state employee contracts to Medicaid/BadgerCare. The state should consider bidding dental services for state employees separately and require that Medicaid/BadgerCare recipients be served as part of the contract."

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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Health Insurance Reform—Promises & Pitfalls

From "Patient Cost-Sharing Innovations: Promises and Pitfalls" by Sally Trude and Joy M. Grossman, an Issue Brief published by the Center for Studying Health System Change, 1/04:

"Over the next decade, health plans and employers will refine patient cost sharing to encourage workers to seek more cost-effective care, according to a panel of market and health policy experts at a Center for Studying Health System Change conference. Instead of using a single, large deductible, employers and health plans will likely vary patient cost sharing by choice of provider, site and type of service, so patients choosing less effective options pay more. Employers also will try to limit financial hardships for low-income workers by, for example, varying cost sharing based on workers' income. However, significant obstacles could hinder the effectiveness of emerging cost-sharing strategies, including inadequate information on quality of care and provider resistance."

Patient Cost-Sharing Trends—"To slow health insurance premium increases, employers in recent years have increased patient cost sharing through higher

deductibles, co-payments and coinsurance. Nationally, employers are estimated to have raised patient cost sharing to reduce average health insurance premiums by 2 percent to 3 percent in 2002 and an additional 3 percent in 2003. How far and how fast employers increase cost sharing will depend on the strength of the economy and the pace of rising health care costs. In a slow economy amid rapidly rising health costs, employers will risk employee rancor by aggressively increasing cost sharing but will back off when the economy improves and labor markets tighten."

Refinements Ahead—"Increased patient cost sharing can be a powerful—but blunt—tool to raise patients' awareness of the true costs of care. As the move toward higher patient cost sharing continues, employers and health plans will refine cost sharing approaches. Without refinements, patients will cut back on both needed and discretionary care when faced with higher out-of-pocket costs. As a result, seriously ill and low-income workers may face financial and medical hardships. Still stinging from the managed care backlash, most employers are likely to increase cost sharing while maintaining broad patient choices."

Cost-Sharing Innovations—"Going forward, employers are likely to adopt layers of deductibles, co-payments and coinsurance instead of offering health plan options with a single, high deductible. Degrees of patient cost sharing will be tied to choice of provider, the site of service and the type of service. These innovations will include cost-sharing tiers to encourage patients to use the most efficient hospital and physician networks. Higher co-payments and coinsurance will be specific to the site of care, for example, with lower out-of-pocket costs to encourage physician office visits—where care is less expensive and better coordinated—and higher patient cost sharing for hospital emergency department visits. Patient cost sharing also will vary by type of service. Imaging services, for example, might have higher cost sharing than office visits, with an aim of reducing inappropriate use of new technology."

Tying Cost Sharing to Income—"If employees choose a less cost-effective option, employers will pass on almost all of the additional cost associated with that choice. To temper concerns that lower-income workers may be unduly penalized, employers may vary cost sharing by income. One approach would be for employers to set maximum annual out-of-pocket spending limits based on income. Employers used to have different cost sharing for hourly and salaried workers, but those distinctions disappeared under managed care where there was little or no cost sharing. As cost sharing increases, companies are likely to reintroduce earning level differentials."

Patient Education Challenges—"despite employers' interest in patient cost sharing, the panelists agreed that the infrastructure for supporting patient decision making is still under development. Prices would need to be much more transparent than they are now to permit informed decisions. In addition, measures needed to assess and compare the quality of care provided by individual physicians remain at an extremely rudimentary state of development. The next step will be to determine overall rates of compliance with evidence-based guidelines from administrative data."

Aligning Provider Incentives—"Providers also will play a crucial role in cost-sharing innovations. As cost sharing increases and becomes more complex, patients will look to their practitioners for guidance in making cost-effective medical decisions. Patients will need to talk with their caregivers about cost-sharing requirements and their ability to pay. The new ideas about cost sharing would promote prevention and reduce discretionary and overused services, circumventing some of the distortions in utilization and charges seen under traditional insurance."

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"Shouldn't we be able to decide not to decide about consumer driven healthcare?"

"The effectiveness of cost-sharing innovations may be limited by providers' own financial incentives. At the same time that the pendulum is swinging back to higher cost sharing, provider payment trends are returning to fee-for-service arrangements, creating financial incentives for practitioners to provide more services. There are enormous economic disincentives for providers to invent ways to reduce overuse. There's absolutely no reason in favor and every reason against a hospital figuring out how many bypass surgeries are totally inappropriate and getting rid of them. Employers and health plans need to work to align cost-sharing innovations with efforts to change provider payment incentives through such measures as pay for performance, where providers receive bonuses for meeting certain quality standards."

Medicare Reform—"Let the Tweaking Begin"

From "Time Will Tell Who and How Much Drug Bill Helps" by Thomas D. Rowley, a weekly RUPRI commentary, 1/30/04:

"Corporate ag giants aside, rural interests are all too familiar with the hind teat of federal assistance. With too few exceptions, the wants and needs of rural people and places are an afterthought in our Nation's policy process. The Medicare Prescription Drug Bill passed and signed in December may well be one of those exceptions—at least in the short term."

" 'For the next 18 months, there's a lot to like in this bill from a rural perspective,' says Keith Mueller, director of the Rural Policy Research Institute's Center for Rural Health Policy. 'When November 2005 rolls around, we just don't know.' "

"Indeed, the thousand-plus-page behemoth contains a long list of goodies for rural doctors, clinicians, and hospitals—$28 billion worth in reimbursement provisions that bring them closer to a level playing field with their urban counterparts."

"The question marks appear when the drug program enrollment opens, benefit kicks in, and competition-theoretically at least—begins. That's because the bill's tilt toward privatization could spell big trouble for rural areas. Remember Medicare+Choice—the program that tanked in rural America because private plans felt they couldn't make enough money there? 'The crafters of the legislation believe they've come up with the model that overcomes challenges to competition in rural areas,' says Mueller. 'We'll see.' "

"Wayne Myers, MD, is immediate past president of the National Rural Health Association. NRHA supported the bill because of the rural provisions. But he has his doubts. 'We got seduced by the rural candy. I personally think it's not a very good bill, despite the good that it does for the rurals,' says Myers, citing what he calls a lot of 'doctrinaire stuff that just doesn't make sense.' "

"For a concrete example of that doctrinaire stuff, look at rural pharmacies. Paul Moore humbly describes himself as 'a pharmacist in rural Oklahoma.' Truth be told, he's also an expert in issues facing rural pharmacies and the policies that help, and harm, them."

" 'I think there will be disenchantment on the part of seniors when they understand what this law does,' says Moore. 'I think it needed to happen, our seniors needed the help... but the unintended consequences are the issue. They could end up coming back five, ten years down the road trying to fix things they've damaged irreparably.' "

"In particular, Moore fears that the law endangers rural pharmacies by granting too much control to pharmacy benefits managers-the middle men between the insurer and the insured—who will continue steering and even coercing seniors to use their own mail order pharmacies. True, the law allows beneficiaries to get their drugs at local pharmacies instead of mail order pharmacies, if—and it's a mighty big if—the beneficiary pays a larger co-payment."

"Moore worries that small-town pharmacies by the score, cut out of the game by these rules of unfair competition, will have no choice but to turn out the lights and lock the doors, leaving rural seniors—and all other rural folks for that matter—with no one to consult about medications and no one to go to for a prescription that needs to be filled now rather than a week or two or three."

"Finally, there's the matter of budget and the long-term sustainability of a $400 billion entitlement—oops, make that $530 billion according to the numbers to be released Monday in the President's budget. Where's the money going to come from for that? Not taxes."

"No one I spoke with thinks the law is set in stone. Yes, it will live on—who's going to take the drug benefit away from seniors now that they finally have it? But, they say, it will likely change. 'I can't get too wrapped around the axle about it,' quips Myers. 'All we can do is hope that it doesn't take 20 years to overcome the bad parts.' "

"Moore agrees. 'There are some really good things in the bill,' he says, 'but there are some other things that really need tweaking if it's going to help rural America as much as it could and as much as it should.' Let the tweaking begin."

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"It is hard to seek perfection standing still."

Rural Nurse Leaders Redesign Work

From a report to RWHC, "MESH/Cooperative Nursing Staff Sampling Project 2003," by Dick Reynolds & Cheryl Pedersen at the University of Wisconsin Hospital and Clinics MESH program, 2/2/04; the report is available at <www.rwhc.com>:

"In the fall of 2002, nurse leaders from the Rural Wisconsin Health Cooperative hospitals were struggling to recruit and retain RNs. They also were interested in redesigning the role of LPN's and CNA's to maximize their contributions. The nurse managers brought their concerns to the UW Hospital MESH consulting group, and together they planned a project to gather extensive data on the actual activities performed by nursing staff on the Medical/Surgical Units at their hospitals."

"The data collection process was modeled after a process used first at San Joaquin Hospital in California in the 1970's and repeated several times by the MESH group at many hospitals around Wisconsin and the Midwest. The process involves trained nurse observers logging activity information on all nursing staff employees working on the Med/Surg unit of the hospital. These data collectors are trained to categorize each activity the patient care staff are performing into one of 37 observed tasks. The data is collected by way of instantaneous observation at a specific clock time, with 6 collection cycles per hour. So the observers collect 6 'snapshot' views of all unit staff during each hour. The 37 activities are divided into four main activity groups: Direct Care, Indirect Care, Unit Related and Personal."

"Data was collected between May 2003 and September 2003. The data collection schedule at each facility included eight shifts of 8.5 hours each (3 day, 3 evening and 2 night shifts). Shifts were scheduled on multiple days of the week with one or two weekend shifts included. Each patient unit staff person was assigned into one of 6 categories: Charge Nurse, Staff RN, LPN, CNA, Health Unit Clerk and Other. 'Other' was used infrequently for a specific staff group defined by a few hospitals."

"The hospitals in the study were all quite similar in services and size, with each being the only hospital in a smaller sized Wisconsin town and the Med/Surg units ranged from 5 to 25 occupied beds. All ten of the hospitals have an ICU unit and eight have birthing units separate from the Med/Surg area."

"The sum total of data collected at the ten hospital Med/Surg units was 4,566 staff hours observed and 27,400 specific observations. Participants were given detailed data about staff time spent in the various activities on each shift and about the type of staff activity performed throughout the 24-hour day."

Findings

"Since a primary purpose of the study was to assist with RN recruiting and retention, we did extensive analysis of the RN activities. Prior to the study, we met with the nurse executives from the 10 facilities to try to understand what they wanted to look for. The executives identified 16 of the 37 activities that should not be the first priority for their RN staff to perform (basic ADLs, clerical, errands off the unit, bathing and basic hygiene, etc). The data shows that RNs spent 18.4% of their time in these activities."

"Other major time-consuming activities for RNs included Charting (22%), preparing and administering medication (16%) and shift report (8%). Although these are activities that managers would expect RNs to perform, they are viewed as candidates for efficiency and streamlining. A small change in time required to complete these functions could have a major impact on the RN activity and the staff cost to operate a patient care unit."

"We collected data and provided reports on activities preformed each hour of the day. It is noteworthy that a major share of the Direct Care work occurs early in the shift and then tapers off throughout the rest of the shift. This phenomenon essentially holds true for each of the three shifts. Work style, work priorities and work organization all contribute to this. This routine has implications for patient scheduling and patient safety."

Conclusions

#1—"The range of RN time in 'Direct Care' varied among the ten hospitals from 35% to 49% with an average of 42%. The group set a benchmark target of 50% of RN time in direct care. The challenge was to find other activities for RNs to eliminate or delegate to other staff, and redirect them to direct care activities. Objectives included increasing time RN's spend in patient teaching and patient communication and reducing time assisting with Activities of Daily Living."

#2—"Nurses spend an average of 8% (40 minutes per shift) in formal shift-change report – with a range of 4 to 12%. The group goal is to move to a more efficient report that would require only 4% (20 minutes) of RN staff time. In most facilities, the shift change report is given behind closed doors and thus staff is not available to patients during this time. Reducing this block of shift report time and allocating it back to patient care is the group objective."

#3—"The two largest time consuming activities are charting (22%) and medication preparation and administration (16%). The fact that these are mostly Direct Care activities is a good thing, but the safety, efficiency and technology implications of both activities are enormous. The 10 hospitals are reviewing this data and where appropriate, they are planning changes in process to streamline these functions."

#4—"Personal time averaged 9% for all staff (6.8% for staff RNs). 9% represents 45 minutes per shift. Since the data collection process ran right through any lunch period or break time, the 45 minutes in reality translates to a 30-minute lunch and one 15-minute break each shift. The nurse executives were concerned that this was low and may not provide enough 'time away' for their staff. Their conclusion was that 9% to 12% personal (including lunch) is a minimum, and the lack of rest and break periods appeared to be a larger problem than any abuse of personal time that may have occurred."

#5—"The proportion of staff time spent in 'Direct Care' activities was quite consistent from day to evening shift. This reflects the increasing numbers of PM shift admissions and late surgical cases returning to the unit."

#6—"Charge nurse roles fell into two distinct categories: Some who were very 'supervisory' and provided less than 10% of their time in direct care; and those who spent more than 30% time in direct care and worked much more like a staff nurse."

#7—"Items that were pre-screened by nurse executives as tasks that should be lower priority for RNs ended up consuming 18.4% of staff RN time. Many hospitals are building their work improvement plans around reducing or delegating these activities."

"Each hospital is preparing and beginning to implement its own operations improvement plan based on the opportunities shown in the data summary reports. Elements of those plans include redesigning and rescheduling activities to improve patient service and to

provide a more stimulating and satisfying work environment for hospital nurses. The hospital group is planning a follow-up study to measure the impact of changes they have implemented and will be pursuing grant funding to help cover the costs. Staff satisfaction, patient satisfaction and overall labor cost per patient are measures that can also help assess the impact of the improvement plan."

Half CAH New Benefit—Not From Medicare

From "The Financial Benefits of Critical Access Hospital Conversion for FY 1999 and FY 2000 Converters" by Jeffrey Stensland, Ph.D., Gestur Davidson, Ph.D., Ira Moscovice, Ph.D., in the Working Paper #51, Rural Health Research Center, University of Minnesota, 1/04:

"As of November, 2003, 834 small rural hospitals have converted to Critical Access Hospital (CAH) status. A primary benefit of converting to CAH status is to receive cost-based payments (rather than prospective payments) from Medicare. The small rural hospitals that converted in FY 1999 experienced an average increase in Medicare inpatient and outpatient payments that exceeded $500,000, in fiscal year 2000 inflation adjusted dollars. While Medicare payments increased by 36%, Medicare patient days declined by 8%."

"Prior to January 1, 2004, a hospital had to have 15 or fewer acute care beds and 25 or fewer total beds including swing beds to be eligible for CAH conversion. For this reason, the program has primarily attracted hospitals with a low average daily census. These small hospitals frequently had high costs per discharge and often suffered operating losses prior to conversion. In fact, over half of the hospitals that converted to CAH status in either FY 1999 or 2000 were losing money prior to conversion. CAH status dramatically changed the financial status of converting hospitals. Hospitals that converted in 1999 saw their total profit margins rise from –2.5% to an average of 2.3% one year after conversion and 3.7% two years after conversion. Most of the FY 1999 converters can now afford capital improvements, and the data indicate that capital expenditures started to grow significantly two years after conversion. Profit margins for fiscal year 2000 converters increased from a mean of 0% to 2% following conversion, and we expect those margins to grow further as CAHs adjust their operations to maximize their profitability given their new Medicare payment structure."

"The CAH program has contributed significantly to the financial viability of small rural hospitals. This is likely due to a one-time shift to cost-based reimbursement as well as behavioral changes induced by higher payment rates. After conversion, CAHs expanded their outpatient and swing bed services and reduced their home health and SNF operations. However, it is important to emphasize that conversion to CAH status was not responsible for all of the financial changes experienced by CAHs. **Approximately half of the increase in inflation-adjusted facility revenue was due to increases in non-Medicare sources."**

"Future analysis of the financial viability of CAHs will need to address the impact of the rural-oriented provisions of the recent Medicare Prescription Drug Improvement and Modernization Act which include the expansion of the bed limit for CAHs and the establishment of distinct part rehabilitation and psychiatric units in CAHs."

Dr Smith Back in Amazon Clinic

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:

"There are any number of ways by which I know that I am back in Yanamono. Lighting the kerosene lantern as darkness sets in and noting the absoluteness of the darkness once it does fall. Waking at 6 a.m., because it is daylight outside by then, and there are things to do. Walking to the clinic along muddy paths littered with leaves and sticks and interesting insects

and animal tracks in feet that are blistering from the unaccustomed pressures of my molded plastic shoes (the best thing I've found for gaining traction in the ever-present mud). Hearing the drums from the Yagua village as they continue to celebrate the entrance of the New Year. Listening to the sounds of the forest, a never-ending but always changing chorus of frogs, birds, insects, and unknowable creatures. The river is rising rapidly. I may have to see about getting a new *canoa* made."

"Leaving the clinic to go back to the Lodge for lunch, I found the *bufalos* in my path. These large animals, descendants of the Asian water buffaloes, are the successors to the scrawny African cattle that used to be raised here. The *bufalos* survive better on the miserable grass that grows here once the rainforest has been scraped off the earth, so they have taken over in the last few years as the animal of choice for meat. There are 10 or 11 of them in the pasture between here and the clinic, and I am a little nervous around them. Everyone tells me they are harmless, but I have had them charge me a few times, and even though they aren't very well nourished compared to the cows in Wisconsin, they still weigh at least 500 or 600 pounds and can move at an alarming speed."

"Ok, so I leave the clinic, get to the fence between Antonio's field and the pasture, and there is the biggest of the mama *bufalos* just over the fence, giving me the evil eye. I wait. She gnaws at the grass, occasionally looking up to see if I am about to hazard a foray into her territory, warning me off with each glance. She knows she's a whole lot bigger than me, and she knows I'm afraid, so she's not worried."

"Then along comes Wendy, Antonio's five-year-old granddaughter. She must weigh about 35 pounds, and her head does not come up to my waist. But one look at her cocky, lopsided, reckless grin, and you know Wendy is not afraid of anything in the world that I could think of, and certainly has no fear of *bufalos*. Sure enough, she skips lightly up one side of the stile and lightly down the other, stepping into the pasture about three feet in front of the big *mamacita*. Mama *bufalo* looks at Wendy, snorts, gives her massive head a shake, then turns and ambles away from the river, into the underbrush. I scramble quickly over the fence and follow Wendy along the path, as she chatters happily at me."

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