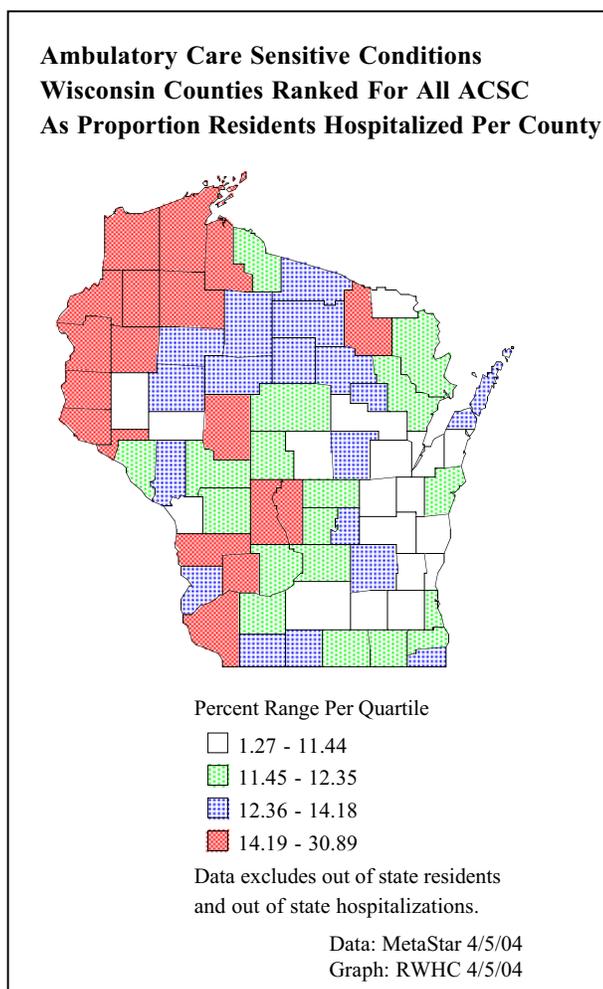


Review & Commentary on Health Policy Issues for a Rural Perspective – May 1st, 2004

Wisconsin Can Choose Healthier Communities

From *AHRQ Quality Indicators—Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Care Sensitive Conditions*, Rockville, MD: Agency for Healthcare Research and Quality, 2001. AHRQ Pub. No. 02-R0203:



“Prevention is an important role for all health care providers. Providers can help individuals stay healthy by preventing disease, and they can prevent complications of existing disease by helping patients live with their illnesses. To fulfill this role, however, providers need data on the impact of their services and the opportunity to compare these data over time or across communities. Local, State, and Federal policymakers also need these tools and data to identify potential access or quality-of-care problems related to prevention, to plan specific interventions, and to evaluate how well these interventions meet the goals of preventing illness and disability.”

“The Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQIs) represent one such tool. Local, State, or national data collected using the PQIs can **flag potential problems resulting from a breakdown of health care services by tracking hospitalizations for conditions that should be treatable on an outpatient basis, or that could be less severe if treated early and appropriately.** The PQIs represent the current state of the art in measuring the outcomes of preventive and outpatient care through analysis of inpatient discharge data.”

What Are Prevention Quality Indicators?

“The PQIs are a set of measures that can be used with hospital inpatient discharge data to identify ‘ambulatory care sensitive conditions’ (ACSCs). ACSCs are conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease.”

“Even though these indicators are based on hospital inpatient data, they provide insight into the

“There are only two ways to live your life: as though nothing is a miracle, or as though everything is a miracle.” Albert Einstein

quality of the health care system outside the hospital setting. Patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored or if they do not receive the patient education needed for appropriate self-management. Patients may be hospitalized for asthma if primary care providers fail to adhere to practice guidelines or to prescribe appropriate treatments. Patients with appendicitis who do not have ready access to surgical evaluation may experience delays in receiving needed care, which can result in a life threatening condition—perforated appendix.”

“The PQIs consist of the following 16 ambulatory care sensitive conditions, which are measured as rates of admission to the hospital:

- Bacterial pneumonia
- Dehydration
- Pediatric gastroenteritis
- Urinary infections
- Perforated appendicitis
- Low birth weight
- Angina without procedure
- Congestive heart failure
- Hypertension
- Adult asthma
- Pediatric asthma
- Chronic obstructive pulmonary disease
- Uncontrolled diabetes
- Diabetes, short-term complications
- Diabetes, long-term complications
- Lower extremity amputations (diabetes)”

“Although other factors outside the direct control of the health care system, such as poor environmental conditions or lack of patient adherence to treatment recommendations, can result in hospitalization, the PQIs provide a good starting point for assessing quality of health services in the community. Because the PQIs are calculated using readily available hospital administrative data, they are an easy-to-use and inexpensive screening tool. They can be used to pro-

RWHC Eye On Health



Silo Philosophy: "Silos are misused as a metaphor for people working in isolation; while they need closed space for fermentation, this is part of a larger cow-field-silage cycle. Healthcare could learn from that."

vide a window into the community—to identify unmet community health care needs, to monitor how well complications from a number of common conditions are being avoided in the outpatient setting, and to compare performance of local health care systems across communities.”

How Do You Use PQI?

“While these indicators use hospital inpatient data, their focus is on outpatient health care. Except in the case of patients who are re-admitted soon after discharge from a hospital, the quality of in-

patient care is unlikely to be a significant determinant of admission rates for ambulatory care sensitive conditions. Rather, the PQIs assess the quality of the health care system as a whole, and especially the quality of ambulatory care, in preventing medical complications. As a result, these measures are likely to be of the greatest value when calculated at the population level and when used by public health groups, State data organizations, and other organizations concerned with the health of populations.”

**Wisconsin Residents In Wisconsin Hospitals
Ambulatory Care Sensitive Conditions (ACSC)
(1st 3 Quarters of 2003)**

	Hospitalizations		
	Number	% ACSC	% All
Bacterial Pneumonia	15,743	21.88%	2.43%
Congestive heart failure	14,905	20.72%	2.30%
Chronic obstructive pulmonary disease	7,114	9.89%	1.10%
Diabetes Cluster	7,021	9.76%	1.08%
Dehydration	6,999	9.73%	1.08%
Urinary infections	6,357	8.84%	0.98%
"Other" Cluster	13,804	19.19%	2.13%
Total ACSC Hospitalizations	71,943	100.00%	11.11%
Total All Hospitalizations	647,308		100.00%

Other: Pediatric gastroenteritis, perforated appendicitis, low birth rate, angina w/o procedure, hypertension & asthma.

Data: Wisconsin Bureau Healthcare Information
Software: AHRQ Prevention Quality Indicators: Software Version 2.1
Analysis Using PQI Software: MetaStar, 4/1/04
Analysis Using Metastar Data: RWHC, 4/7/04
Graph: RWHC, 4/13/04

“These indicators serve as a screening tool rather than as definitive measures of quality problems. They can provide initial information about potential problems in the community that may require further, more in-depth analysis.”

“State policymakers and local community organizations can use the PQIs to assess and improve community health care. **One of the most important ways we can improve the quality of health care in America is to reduce the need for some of that care by providing appropriate, high-quality preventive services. For this to happen, however, we need to be able to track not only the level of outpatient services but also the outcome of the services people do or do not receive.**” Will we?

Rural Hospitals Get Real About Prevention

From “Health Promotion and Disease Prevention by Small Rural Hospitals: Reasons, Obstacles, and Enablers” by Peter C. Olden, Steven J. Szydlowski, Neil G. Armstrong in the *Journal of Healthcare Management*, Mar/Apr 2004:

“This article reports research done regarding the question, what are the reasons, obstacles, and enablers for health promotion and disease prevention (HPDP) by small rural hospitals (SRHs)? Answers

should interest rural hospital leaders and scholars concerned with community health, rural health, hospitals, and HPDP. From reading this article, SRH leaders can better understand reasons for HPDP, obstacles to HPDP, and enablers of HPDP. In this study, the unit of analysis was the small rural general hospital, which was a nonspecialty hospital not in an MSA that had fewer than 110 beds. Hospital selection for interview research was criteria based and purposeful: small size, rural location, general acute services, and active in HPDP. Researchers identified nine hospitals in rural Pennsylvania, and all agreed to participate.”

Reasons for Health Promotion & Disease Prevention

“The respondents indicated that their hospital often provided HPDP in response to the external environment. Strategic direction, vision, and mission (which position an organization in its market and environment) impelled most of the SRHs to offer HPDP. Respondents stated that their hospital mission includes improved health status of the local population, so they made HPDP available. Local community characteristics, such as health status, were also important reasons for HPDP by these SRHs. When a health problem was identified in a community, then an SRH would try to respond with HPDP. Executives said the following:

- ‘We want to be the hospital of choice.’
- ‘We are trying to become more than a place for sick care.’
- ‘Market value exists when advertisements are made promoting health behavior . . . this may persuade individuals to use our hospital for inpatient needs’.”

“Hospitals sometimes provided HPDP because external philanthropy, grants, or donations were available for such service. In three instances, HPDP was offered because of an internal leader or champion who built momentum and obtained HPDP support from other stakeholders. An interesting finding is that several hospitals developed a particular HPDP service after a personal/family experience led an employee to become a change agent for a specific ‘cause’. However, some hospitals said their HPDP was not provided in response to specific employees, board members, or physicians. Those stakeholders tended to support HPDP but not initiate it. Alternatively, some

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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board members who were local employers pushed health promotion to improve employee health.”

Obstacles

“Although the external environment created reasons for HPDP, it also created obstacles. Rural communities’ attitudes toward their hospitals and toward healthy behavior impeded HPDP, as did local lifestyles. One CEO explained, ‘healthcare is not a top priority for the community, and people do not understand lifestyle implications on health.’ Another added, ‘health is not a community priority . . . a barrier is that most people take health for granted.’ Local attitudes also led people to view their local hospitals as a place for sickness but not for health: ‘the community does not view the hospital as a place for health’, and ‘the community sees the hospital as a place to die.’ Executives want to change hospitals’ image so that communities see hospitals also as places for well-being and health improvement.”

“Respondents identified other community characteristics as obstacles to HPDP, including low educational levels, weak local economies, and large older populations. The educational and economic factors reduced receptiveness to HPDP and hospitals’ ability to offer it. The belief that ‘unemployment and low average income affect patients’ ability to pay for preventive care’ was echoed in ‘economic status is poor with constraints on the population’, (SCH). Resource availability is an obstacle.”

“The SRHs prioritized services with inpatient care first. CEOs believe the hospital must be financially stable to provide core services, and HPDP could come after the core services are ensured. One CEO noted favorable Medicare changes could increase hospital HPDP because Medicare is a large portion of the payer mix. To remain financially viable, SRHs emphasize revenue-generating core inpatient and outpatient services, although their missions may be broader. The **‘mission is for community health, but the incentive**

is for procedures,’ so the hospital tries ‘to improve health . . . while maintaining core services’.”

Enablers

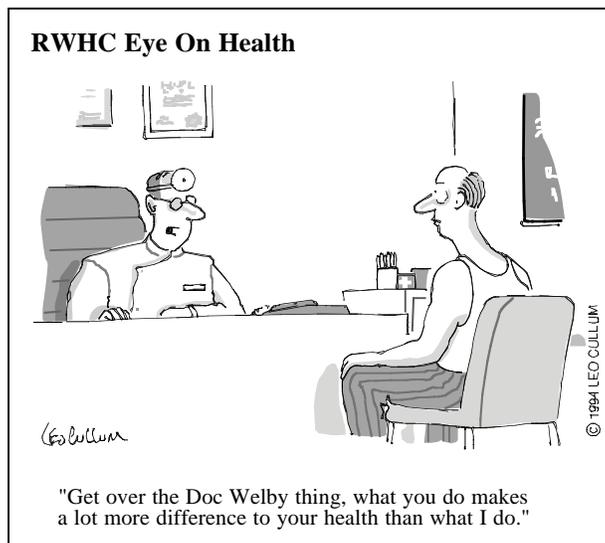
“Small rural hospitals face tough obstacles when offering HPDP. How do they do it? All interviewees stated that interorganizational relationships (IORs) increased their ability to provide HPDP. Collaboration among health providers, community organizations, and employers helped pool scarce resources for HPDP. Most CEOs emphasized that their hospital is only one of many health stakeholders that create HPDP, so the hospital works with these stakeholders. Partnerships with schools enabled SRHs to offer health programs for students of all ages. Hospital-school collaborations were perhaps the most common. Besides linking with schools to enable HPDP, the SRHs also collaborated with churches, youth groups, civic clubs, fraternal groups, employers, fire squads, and other organizations. These IORs enabled rural hospitals to overcome barriers by obtain-

ing HPDP sites and facilities, enlisting workers, acquiring materials, gaining sponsorships and funds, disseminating health information, and reaching target groups.”

Discussion and Practical Recommendations

“The CEOs interviewed felt that their hospitals should help create health, although medical care is their top priority. The interviews found that cooperative relationships enable HPDP with additional people, facilities, supplies, equipment, legitimacy, interpersonal connections, knowledge, funds, and resources. To accomplish such results, leaders should look broadly within and beyond their community to consider a wide variety of potential partners. Then, SRH leaders must really collaborate with the organizations and not try to ‘manage’ them.”

“Leaders must build trusting relationships by sharing plans, power, resources, information, control, and



glory, which may be hard for take-charge CEOs. In addition, they must remember that other stakeholders may question hospital motives for HPDP and may not think positively of the hospital. The leader must be perceived as truly interested in community health because public perceptions that hospital HPDP is being done only for market share will reduce others' trust and cooperation. Some people may view HPDP to improve health status as wasted funds that should have supported inpatient care. When such beliefs are encountered, strong leadership, communication, and interpersonal skills are needed."

"Paraphrasing McGinnis, Williams-Russo, and Knickman (2002), to really improve health, public policymakers must focus on health policy rather than just healthcare policy. Executives of SRHs should consider public policy advocacy to seek more incentives, and fewer disincentives, for rural HPDP. Low/no reimbursement is a barrier to HPDP, and better reimbursement policy could enable more HPDP. Because IORs enable HPDP, public policy could be sought to promote them."

Higher Ratio of Specialists Lowers Quality

From "Medicare Spending, The Physician Workforce, And Beneficiaries' Quality Of Care" by Katherine Baicker and Amitabh Chandra in *Health Affairs*, Web Edition, 4/7/04:

"Recent research has found large and persistent differences across states in the quality of care that Medicare beneficiaries receive. One way to measure these differences is through differences in the use of effective, high-quality care, such as the administration of beta-blockers after heart attacks, mammograms for older women, influenza vaccines, or eye exams for diabetics."

"These procedures are relatively inexpensive, are known to have desirable medical benefits, and are rarely contraindicated. It is therefore puzzling that the use of these procedures varies so widely between states; for example, in 2000 the use of beta-blockers within twenty-four hours of admission for patients with heart attacks and without contraindications

ranged from 50 percent in Alabama to 86 percent in New Hampshire."

"In this paper, we first determine whether quality differences can be explained by differences in Medicare spending. That is, are states where there is more spending per Medicare beneficiary also more likely to provide effective care? Clearly, spending more is unlikely to cause lower-quality care but rather serves as a marker for a particular style of health care provision or use of resources. Something in the underlying infrastructure or allocation of resources may drive both higher spending and lower quality of care."

"We next examine whether high-spending states provide more care along other dimensions, such as multiple specialist consultations, hospitalizations, and use of intensive care units (ICUs) in the last six months of life. Prior research has shown that end-of-life care is extraordinarily costly but not correlated with the underlying sickness of the population, patient outcomes, or patient satisfaction. Finally, we explore potential mechanisms through which intensive care might crowd out high-quality care. We analyze the effect of the underlying physician workforce (generalists versus specialists) on both spending and quality differences across states."

"States that spend more per Medicare beneficiary are not states that provide higher quality care. In fact, additional spending is positively correlated with end-of-life care but negatively correlated with the use of effective care. While higher spending per se is unlikely to cause a drop in the use of high-quality care, it seems to be a marker for a particular pattern of care. Our analysis suggests that the mix of the physician workforce plays a critical role in the use of highly effective care. States with relatively more general practitioners have both higher rates of use of effective care and lower spending."

"Given the reliance on cross-area variation in spending and quality, inferences about causal mechanisms should be made with great caution. First, ecological inferences always raise concerns about omitted variables, such as risk adjustment or legal environment. This is unlikely to be a problem in this analysis, for three reasons. First, the QIO quality measures were specifically selected to be robust to the absence of risk adjustment. Second, for incomplete risk adjust-

ment to drive these results, it must also be the case that sicker patients medically require less of the 'high-quality' care—a highly unlikely scenario. Third, the results are equally strong in the within-state panel-data analysis, which controls for any persistent differences in illness in state populations, malpractice laws, or regulations.”

“A second concern might be that specialists locate in areas where patients are sicker and that sicker patients are more likely to be hospitalized for longer stays or admitted to the ICU. If this were true, then the positive relationship between specialists and end-of-life spending could be spurious. Here, too, several factors limit this potential bias. First, examining care that is based only on the sample of deceased people implicitly controls for the underlying sickness of the patient population. Furthermore, other researchers have found that underlying population risk does not seem to drive the presence of specialists and that outcomes are not improved by increased access to these specialists. In particular, in the area of neonatology, specialists are associated with neither higher risk nor lower mortality. The results on the ineffectiveness of specialists for the provision of high-quality care are thus consistent with the findings of a broader literature.”

“What causes some states to be high spenders and provide lower-quality care, while others are low spenders and provide higher-quality care? One possibility is the composition of the medical workforce. States where more physicians are general practitioners show greater use of high-quality care and lower cost per beneficiary. It is possible that although areas with more specialists do not provide higher-quality care along these dimensions, they may be better at the treatment of more acute conditions. It is also possible that areas ‘specialize’ in different types of care: Some areas specialize in primary care, while others may specialize in the delivery of technologically aggressive care for heart attacks. We do not find evidence of this here: States with

more specialists have neither lower mortality rates from all causes nor reduced post-AMI mortality.”

“This suggests that specialists are clustered in areas where costly intensive care crowds out high-quality care and that one mechanism for this is a lesser presence of general practitioners. Encouraging greater access to general practitioners, or involving specialists in the provision of effective care, could improve the overall quality of care received by elderly Americans.”

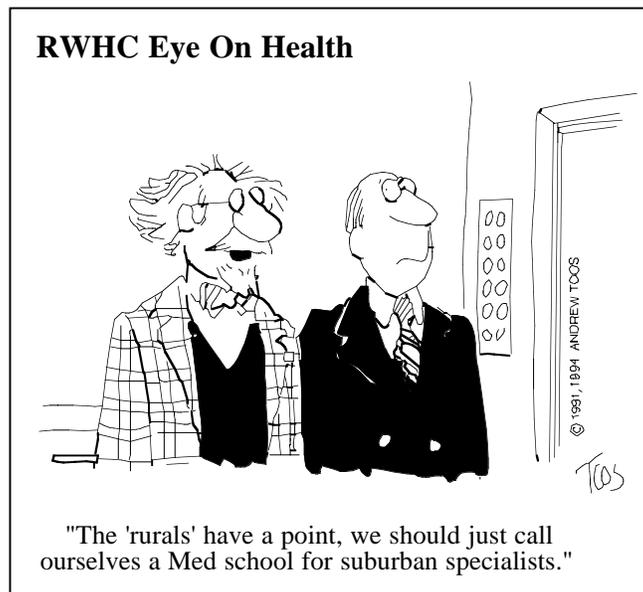
WI Leadership Calls For Med School Reform

From “Who Will Care For Our Patients? Wisconsin Takes Action To Fight a Growing Physician Shortage,” a new study by the Wisconsin Hospital Association and the Wisconsin Medical Society: The complete report is available at:

www.wha.org/physicianshortage3-04.pdf

“In early 2003, the Wisconsin Hospital Association, together with support from the Wisconsin Medical Society, established a Task Force on Wisconsin’s Future Physician Workforce. The charge to the Task Force was to: (1) undertake a needs assessment of current and future physician supply and distribution issues; (2) identify factors that are impediments to meeting those needs; and (3) find specific strategies that will help assure adequate future access to physicians for Wisconsin patients and communities.”

“Task Force membership included representation from physician practice groups, the Wisconsin Medical Society, the Wisconsin Academy of Family Physicians, the Rural Wisconsin Health Cooperative, hospitals and health systems, the medical schools in Wisconsin and others. After reviewing existing data and analysis, the Task Force has



concluded that an unmet current need exists for physician services, and that the problem will likely grow worse in the future unless aggressively managed. A number of major changes are necessary in order to have a sufficient number of physicians to meet the anticipated demand in the future.” These critically needed changes are as follows:

Goal I. “Recruit, enroll and train in Wisconsin’s medical schools individuals who are likely to practice in Wisconsin, especially underserved parts of Wisconsin.

- Increase the number of medical school students.
- Establish goals for medical schools to set and achieve targets for successful recruitment and retention of students from underserved areas.
- Create regional specialty training networks to expose trainees to urban and rural underserved sites.
- Develop/replicate programs that attract students to medical school.
- Create a programmatic focus or “School within a School” to focus on underserved areas.
- Begin the promotion of health careers at the middle school level.”

Goal II. “Develop care delivery models that will enhance and leverage physician resources.

- Provide for funds for pilot projects for ‘team care models’.
- Conduct pilots and studies of alternative delivery models.
- Prepare medical students and residents to work with Advanced Practice Providers.
- Investigate potential mentoring opportunities using retired, part time, and administrative physicians.
- Evaluate shortening of the timeframe for medical education.”

Goal III. “Create policy and practice that encourage physicians to enter and remain in practice in Wisconsin. Create similar policies to encourage physicians to return to Wisconsin to practice.

- Create funds for loan forgiveness for physicians to stay in state after their residencies.
- Establish incentives to ensure specialists are adequately dispersed across the state.

- Identify and publish best practices for recruitment and retention.
- Maintain Wisconsin’s favorable medical malpractice environment.
- Ensure adequate payment rates to support physician recruitment.
- Provide monetary incentives to address selection of locale and specialty.”

Goal IV. “Provide for adequate and targeted funding for graduate medical education.

- Increase state funding for GME positions.
- Increase Medicaid GME and tie increases to Task Force goals.”

Goal V. “Develop an infrastructure to guide medical education policy in Wisconsin.

- Create a Wisconsin advisory council to monitor, predict and recommend activities to maintain an adequate supply of physicians for Wisconsin.
- Create a process to maintain adequate data about physician supply and demand.”

“These goals and action steps require the efforts of Wisconsin’s medical schools, the provider community, and policymakers to enact changes in medical education and physician practice.”

The 2004 RWHC Nurse Excellence Awards

Susan Golz, RN, at Divine Savior Healthcare in Portage is the recipient of the 2004 RWHC Award for Excellence in Nursing Clinical Practice.

Teresa DeNucci, BSN, at Stoughton Hospital has received the 2004 RWHC Award for Excellence in Nursing Management.

The RWHC Nurse Excellence Awards were initiated by the nurse executives of RWHC’s 29 member facilities to recognize the high quality of nursing practice provided by hospitals serving rural communities. Nurses in community hospital settings must be highly educated and well rounded in terms of clinical practice, in addition to having the ability to respond to a

variety of age groups, diagnoses, and patient emergencies. The establishment of this award recognizes that excellence in nursing practice is a valuable asset to rural communities in the state of Wisconsin. From the hospital nomination papers:

“**Sue Golz** has worked for Divine Savior for her entire nursing career. As a senior staff member at the hospital, Sue has been involved with various committees in the hospital. Sue has been a member of our Nursing Practice Committee, Ethics Committee, Perinatal Committee, as well as a childbirth educator. Sue is recognized as a leader and expert in her clinical role as an obstetrics nurse. She dedicates time and talent to helping to define nursing practice standards for the intrathecal and epidural patients and helping staff meet competency requirements.”

“Sue is frequently asked to orient new members of the OB staff because of her ability to work with new staff members. Sue is positive, upbeat, and highly organized. Her standards of practice excel through her dedication and caring for patients and families. She spends extra time educating patients and team members on the philosophy of good customer serv-

ice. Sue maintains her Neonatal Advanced Life Support certification, Advanced Life Support in Obstetrics, and attends related continuing education on a regular basis.”

“**Teresa DeNucci** came to Stoughton Hospital as a staff nurse and has progressed to clinical supervision, management, and currently serves as Director of Ambulatory Services. Teresa directly manages the emergency room, registration, urgent care, infection control, occupational health, cardiopulmonary, and provides administrative oversight for medical imaging. Teresa is a dynamic leader who best demonstrates her expectation for her staff by her own examples. She has incredible high energy and is always positive, supportive, and fair.”

“Teresa regularly incorporates employee empowerment into her leadership style. One of her peers states, ‘Teresa is a strong advocate for nurses; always takes the necessary steps needed to empower the nurses she supervises.’ Teresa has worked to grow her staff and now many of them are in charge of major departmental initiatives.” **Congratulations and thanks to both Teresa and Sue!**

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