

Review & Commentary on Health Policy Issues from a Rural Perspective - December 1st, 1999

Seniors At Bat: Challenge Medicare's Constitutionality

RWHC is supporting a Minnesota based, grass roots, reform initiative known as the Medicare Justice Coalition but financial support is also needed from many more individuals and organizations; for more information call 651-645-0261 or visit:

www.mnseniors.org/medicarejusticejoin.html

From the Medicare Justice Coalition's November 17th Press Conference, "Opening Comments" by Peter Wyckoff, Executive Director, Minnesota Senior Federation-Metropolitan Region:

"Every American who earns a paycheck pays into Medicare, and every Medicare recipient pays the same monthly Medicare Part B premium of \$45.50, whether they live in Florida, New York, California, or Minnesota. That seems fair."

"But surprisingly, what we get for our money varies dramatically, depending on what part of the country we live in."

"In parts of Florida, New York, California, Michigan, and Arizona, seniors get prescription drugs, dental, vision and hearing services, and even health club memberships free of any additional premiums."

"While at the same time seniors in Minnesota and many other parts of the country have to pay high supplemental premiums, up to \$300 a month, to get any drug coverage. Benefits like dental, vision and hearing services, if available at all, are very limited."



"At issue is an unjust funding formula that punishes beneficiaries, doctors, and hospitals in areas that keep their health care costs down and rewards areas with high health

"The issue of Medicare equity is geography." Peter Wyckoff, Minnesota Senior Federation, 11/17/99
RWHC Eye On Health, 11/20/99

The Rural Health Policy Institute 2000



National Rural Health Association

February 7-9, 2000
Washington, D. C.

202-232-6200 to register or
www.NRHA Rural.org

Much of the BBA Relief (Medicare payment changes) just passed by Congress is the result of a united rural front through and with the NRHA. But much work is still to be done. Join RWHC and other NRHA members at the policy institute to be part of our ongoing fight for additional, necessary federal reforms.

care costs, overspending, overuse, and inefficiencies."

"According to the Health Care Financing Administration, while the cost of delivering health care across the country is said to vary about 14 to 15 percent, the reimbursement by Medicare under both fee-for-service and HMOs varies 211%!"

“Compare, for example, the difference in Medicare payments to HMO’s for a senior in Hennepin County, Minnesota, and a senior in Dade County, Florida. In 1999, a Minnesota HMO receives about \$405 per beneficiary per month while a Florida HMO receives \$778 per beneficiary per month – almost twice as much!”

“The impact of this, on real lives, is that in Minnesota a senior has to pay an average of \$75 per month for an HMO for vital non-Medicare covered services. This is in

addition to their Medicare Part B premium. And for that premium no prescription drug coverage is provided, and he or she will have to pay significant co-pays for each office visit.”

“The Miami resident, meanwhile, pays no premium for HMO coverage, does receive prescription drug coverage, and has no co-pays.”

“The bottom line is, Minnesota seniors and health care providers are being punished because we have an efficient health care system. Clearly, this formula is both unfair, unjust, and must be changed.”

“The issue of Medicare equity is one of geography. It all depends on what part of the country you live in and specifically what county you live in.”

“The inequity of this reimbursement level is causing a crisis in access in rural Minnesota as fee-for-service providers are disproportionately penalized in communities where Medicare spending is already lower than average. As a result some rural hospitals may close and the ability of communities in greater Minnesota to attract and keep physicians will be even further hurt.”

“The Medicare Justice Coalition believes that the Federal Government has created a two-tier Medicare system that is unjust, unfair, and illegal.”

“Today the Metropolitan Region of the Minnesota Senior Federation and the Minnesota Attorney General’s office announce a lawsuit against the Federal government to bring equity to the Medicare reimbursement system, that is now quickly destroying not only public confidence in Medicare, but Medicare itself.”

“The lack of Medicare equity and justice is a cancer destroying Medicare from within. A cancer undermining the very integrity of the Medicare system. A cancer that has created a two tier health care system for older Americans based simply on the happenstance of where a person lives. The time for Medicare justice has come. The time for Medicare equity is long overdue.”

The Senior Revolt -- What Is The Big Picture?

From “Seniors, Attorney General Take on Inequities” by David Shapinsky at <www.ABCNEWS.com>:

“A leading intellectual force for changing the Medicare payment system is Dartmouth University Medical School Professor John Wennberg, co-editor of The Dartmouth Atlas of Health Care.”

“His basic argument is this: Because Medicare payments to health care providers are calculated according to the historical cost of care in an area, Minneapolis HMOs will receive about half of what similar providers get in Miami--a difference of roughly \$4,000 a year.”

“But that doesn’t mean that Miami seniors always do better. In fact, Wennberg argues this discrepancy causes problems for people at both ends of the spectrum. In a high-cost area, like Miami, seniors may receive treatments that are not necessary and do not enhance their quality of life.”

“During the last six months of their lives, for instance, almost 50 percent of Miami seniors will find themselves in an intensive care unit at least once.”

“That, Wennberg argues, ‘has nothing to do with illness. Nor is life expectancy greater in Miami for all the extra care.’ In his view, this means that higher payments do not equal better health.”

“For people in low-cost areas, such as Minneapolis, the lower Medicare payments create a different problem. HMOs have less profit, charge higher premiums, and offer fewer benefits, like prescription drug coverage.”

“As a result, seniors can find themselves burdened by the cost of prescription drugs and, in some cases, forced to go without critical medications. ‘Seniors in Minnesota and other low-cost parts of the country lose on two accounts.’”

“While they ‘don’t get the extra benefits,’ he says, ‘they are still paying about the same in taxes.’ This means, they are ‘subsidizing’ higher-cost regions. And this, Wennberg says, ‘seems unfair and Congress ought to deal with it.’”

The Beginning Of Pro- Rural Health Congress?

At this writing, the Balanced Budget Act of 1997 “Refinement” legislation is about to be passed by the Senate and signed into law (following some very appropriate Senate protests to the dairy pricing mid-west exploitation provisions of the ‘99 Budget Bill.

Below are some of the expected rural-specific highlights from this technical but very important legislation for rural health. This summary doesn’t include provisions which the President has agreed to accomplish through the regulatory process (e.g. postponement of the 5.7% outpatient cuts, postponing the low volume payment caps and limiting the new transfer rule to the original

10 DRGs). The sources for these notes are the Congressional Research Service and House Commerce Committee Staff (thanks to the NRHA!).

Transitional Payments for Hospital Outpatient Prospective Payment System (PPS)--a 3 year hold harmless for rural hospitals with less than 100 beds.

Report on Including Rural Hospitals in Outpatient PPS--require MedPAC to prepare a report within 2 years regarding the feasibility and advisability of including rural hospitals in PPS.

Report to Congress on Rural Home Health PPS--require MedPAC to report to Congress within 2 years on the feasibility and advisability of including rural populations and rural home health agencies in PPS.

GAO Study on Geographic Classification--GAO to study whether the current system for geographic reclassification of hospitals is appropriate for purposes of applying wage indices.

Permitting Reclassification of Certain "Urban" Hospitals as Rural Hospitals--allows for an urban hospital to be considered a rural hospital if the hospital is located in a rural census tract of a large metropolitan statistical area or (2) the hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated as a rural hospital) or (3) the hospital would qualify as a rural referral center or sole community hospital or (4) the hospital meets such other criteria as the Secretary may specify.

Improvement in the Critical Access Hospital (CAH) program--applies the 96-hour length of stay limitation on an average annual basis; permits for-profit hospitals and hospitals that have closed within the past 10 years or downsized to be CAHs. Permits CAHs to elect either a cost-based outpatient payment system or a facility fee plus a fee schedule for professional services or an all inclusive rate. Eliminates co-insurance for outpatient lab at a CAH.

Extension of Medicare Dependent Hospital (MDH) Program--extends through FY2006.

Sole Community Hospitals--permits sole community hospitals that are now paid the federal rate to transition to payment based on FY 1996 costs.

Increased Flexibility in Providing Graduate Physician Training in Rural Areas--permits rural hospitals to increase their resident limits by 30% for both DME and IME payments. Permits non-rural facilities that operate separately accredited rural training programs to increase their resident limit.

Swing Beds--Eliminates requirement that states review the need for swing beds through the Certificate of Need for rural hospitals with less than 100 beds.

Grant Program for Rural Hospital Transition to PPS--permits rural hospitals with less than 50 beds to apply for grants not to exceed \$50,000 for meeting costs associated with implementing PPS.

MedPAC Study of Rural Providers--study on the adequacy and appropriateness of special payments for rural hospitals.

Federally Qualified Healthy Centers and Rural Health Clinics--freezes phase-out of cost based reimbursement at 95% of actual costs in FY2001 and FY2002. Resumes phase-out of cost based reimbursement at 90% in FY2003 and 85% in FY2004. postpones repeal of phase-out by one year until 2005. Requires GAO report within 1 year on the impact of phase-out of cost-based reimbursement.

More Miracle Drugs Fewer Can Afford

From "The Gathering Storm Over Prescription Drugs" by David Rosenbaum, The New York Times, 11/14/99:

"The pharmaceutical industry represents the greatest strengths of American capitalism. And also the weaknesses. The drug companies are enormously profitable, highly competitive businesses on the cusp of a scientific revolution that promises a fabulous financial future. They supply the world with indispensable products made better than they have ever been made before."

"But neither the companies nor their government regulators nor the politicians who pass the laws have found a way to make sure that the vital products of this unfettered market reach all segments of society. Businesses, insurance companies, consumers and especially

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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the elderly are feeling the exploding cost of drugs. And trying to ward off government interference, the pharmaceutical industry is turning increasingly to expensive lobbying and generous campaign contributions.”

“Gradually, all this is coming into focus as a potent political issue, just as health maintenance organizations emerged from nowhere a few years ago to become public enemy No. 1 in health care. In academic, business and political circles, there is now general agreement that change is needed in the nation's drug policies, though there is no consensus on what that change should be.”

“Drug manufacturers are clearly feeling the political heat. For years, they have held their own against complaints from consumer organizations about profits and prices. Now they have more politically influential foes.”

“One is the elderly. AARP, formerly the American Association of Retired Persons, has joined the Clinton administration in its drive to get Medicare coverage of prescription drugs -- one of the main political debates in Washington this fall. The organization reports that one-third of the elderly have no prescription-drug coverage at all, and that many others have high deductibles and caps on the amount of drug expenses they can recover. One-quarter of Americans over 65 pay at least \$500 a year out of pocket for prescription medicine, and 12 percent pay more than \$1,000.”

“Insurers and health maintenance organizations are another foe. They are now paying more for prescription drugs than for hospitalization. Michael Fedyna, chief actuary for Empire Blue Cross and Blue Shield in New York, estimated last month that drugs will represent 15.5 percent of premiums this year and hospital care less than 15 percent. Just three years ago, he said, drugs took 12 cents of the premium dollar and hospitalization 22 cents.”

“Meanwhile, the Journal of the American Medical Association carried a politically sensitive report describing the ways new drug research is often exaggerated in medical journals to the benefit of the pharmaceutical companies financing the studies.”

“In Senate testimony last summer, Schering-Plough chairman and chief executive Richard Jay Kogan, made the case that drug companies have been making for years: The companies must make a handsome profit on their blockbuster drugs because so much of their research goes for naught. ‘Only one in every 5,000 chemical compounds ever reaches the U.S. market, Kogan said. “Bringing a drug to the marketplace takes 12 to 15 years and costs up to \$500 million.”’

“Other drug company officials insist that any effort to control drug prices, as is done in every other developed country, would have the disastrous consequence here of stifling invaluable research. Some Americans may go to Canada to buy prescription drugs, said Mark Grayson, a spokesman for the Pharmaceutical Research and Manufacturers Association, but many more Canadians come to the United States for medical treatment. ‘You have to look at the whole system,’ he said, ‘not pick and choose among the parts.’”

“Meantime, the industry is at the dawn of a new scientific era that should expand the potential for profits. Advances in biotechnology and genomics, the science of identifying genes and how they work, promise a wealth of exciting new miracle drugs in the next decade.”

“‘The new science is going to drive the process such that pharmaceuticals are going to command a larger and larger share of the health care pie,’ said Viren Mehta, head of an investment advisory firm that specializes in the pharmaceutical industry.”

“But the scientific achievements may worsen the industry's political problems. ‘We will want those drugs,’ said Kessler, the Yale dean. ‘They will increasingly treat disease. But they will also increase the disparity we now have between the haves and the have-nots.’”

You Must See *The Insider*
A True Story of Individual Courage &
The Corruption of Two American Giants
The Prequel to Medicine-gate?

How Good Is Health Care For Your Health?

The following is from “Is Medical Care Obsolete?,” a speech by David Lawrence, M. D. (CEO, Kaiser Permanente, the largest single healthcare organization in the country, caring for approximately 9 million people) at the National Press Club, 7/14/99. Given the controversial nature of his message, *Eye On Health* particularly invites alternative views on this issue.

“In 1954 Henry Kaiser, the great industrialist and founder of Kaiser Permanente, spoke to the National Press Club. His message was simple:

‘...many Americans are dying too soon and too many Americans are suffering needlessly because they don't get the medical care they need.’”

“His message is as true today...at the end of the twentieth century...as it was then.”

“Last fall, a group of us from the Institute of Medicine of the National Academy of Sciences published the re-

sults of an intensive multi-year study of health care quality in the United States. We concluded that:

'Serious and widespread quality problems exist throughout American medicine. These problems, which may be classified as underuse, overuse, or misuse, occur in small and large communities alike, in all parts of the country, and with approximately equal frequency in managed care and fee-for-service systems of care. Very large numbers of Americans are harmed as a direct result. Quality of care is the problem, not managed care.'

"In their landmark medical practice studies conducted early this decade, Lucien Leape and his colleagues examined the frequency of medical care accidents that occurred in the hospitals of New York State. The Harvard malpractice studies by Leape, Brennan and colleagues have explored similar data in Boston's leading teaching hospitals. These investigators have documented that mistakes in diagnosis, failure to apply critical preventive precautions, errors in medication use, and failures of equipment and technologies occur with far greater frequency than originally thought."

"Extrapolating from these hospital studies to health care in general, one can conclude that the third leading cause of death in the United States are fatal mistakes that occur as a result of the misuse of the extraordinary medical technologies that we now have available. These accidents are responsible for over 400,000 deaths yearly---more than tobacco, stroke, diet, alcohol, drugs, firearms, or automobiles, and behind only heart disease and cancer. Two thirds of health care accidents are preventable; the other third occur as a result of incomplete science, unexpected complications of medications or surgeries that can be as dangerous as the benefits we would like them to confer. These numbers do not include the impact of failing to treat what we know how to treat. Nor do they include the impact of overzealous use of the care. Rather they point to problems of misuse. Were fatalities from these additional sources added to those from accidents, the number of deaths would climb significantly."

"Aside from the 48 million Americans lacking health insurance, the safety of health care provided in the country is the single most important issue in health care today. The impact of unsafe or incomplete care on human lives and families, as well as its costs to the nation, are unacceptable."

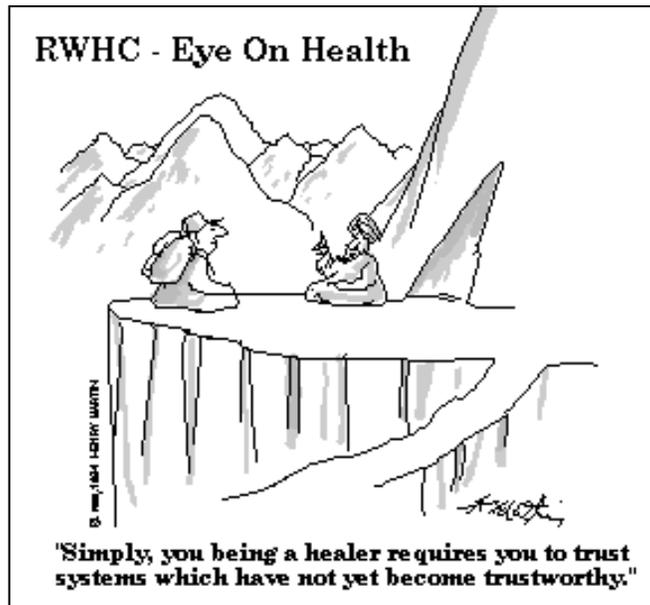
"The starting point for health care, then, has to be to change the way the traditional delivery system works for most Americans. Fortunately, we have a growing number of experiences that suggest how we might do this."

"First, group practice can help doctors improve their care to patients. Since the practice form was popularized by the Mayo brothers in the late 1800's, high performing multi-specialty group practices have enabled physicians to stay more current, incorporate structured, ongoing quality assurance activities, and provide more care continuity for patients. Group practice, especially multi-specialty group practice supported by appropriate electronic clinical information systems, is one cornerstone for building safer care for patients."

"A limited number of "virtual" groups of physicians have been created by linking physicians electronically. The most notable is Intermountain Health Care in Utah, whose record for safety improvement is one of the best in the country. It remains to be seen, though, whether or not these "virtual" organizations can create and maintain the strong safety and evidence based culture and organizational discipline among practicing physicians that is characteristic of the best group practices in the country."

"Second, well organized, integrated care delivery systems, though few in number, bring together the structure, expertise, experience, services, support systems and incentives required to help patients achieve superior quality outcomes, including improved safety."

"You may have seen the movie "As Good as it Gets". Did you boo the callous HMO for not treating the star's son? Of course in Hollywood, a home visit by a kindly specialist saves the day. You and I, however, live in the real world. And in the real world the best outcomes occur in systems of care that help children and their families learn to manage the disease and stop complications before they become serious enough to require major medications, ER visits (usually in the middle of the night), or even hospitalization. Obtaining these results involves skilled teams of professionals, including doctors, nurses, pharmacists, and health educators; the integrated services of home health, advice phone lines, trained ER staff, and effective ER and in-hospital treatment and education when severe complications occur."



“Our science, our technology, our medical care, our understanding of what works and what doesn’t in medicine are the best in the world and getting better.”

“But the safety with which care is delivered in this country is compromised by the delivery system through which most Americans receive it. That century old system can no longer do the job. It is obsolete.”

“We know that safety will be compromised further in this system as the science expands and our technologies grow more powerful in the coming decade of unprecedented breakthroughs that most observers foresee.”

“We know that the starting place for improved patient safety is the formation of organized systems of care that include groups of physicians practicing in carefully structured and supported teams with other professionals, and focused on continuously improving the safety of the care they provide their patients.”

“This is the real patients’ rights issue: the right to safe care that can occur only if we make fundamental changes in the way we organize and deliver the remarkable care we now have available to improve the quality of our lives.”

RWHC & JCAHO Have “Spirited” Debate

The following report was written by Carla Gorski, RWHC’s Health Information Specialist:

Joint Commission on Accreditation of Healthcare Organization’s (JCAHO) Joseph L. Cappiello recently visited with the RWHC Board of Directors meeting to discuss JCAHO initiatives. The hospital administrators had requested the opportunity to share their insights and experiences with the JCAHO accreditation process. Mr. Cappiello, the Vice President of Accreditation Services, opened the discussion by summarizing the recent policy change made by JCAHO to eliminate the notice for Random Unannounced Surveys. A JCAHO task force on improving the accreditation process is currently focusing on the survey process. A long term goal of this initiative is for the survey current process to evolve to a point at which the health care organization’s “system” is surveyed, rather than an organization’s compliance with individual standards.

Mr. Cappiello acknowledged that one of the biggest challenges facing JCAHO is training the surveyor. He noted that the reputation of JCAHO “lives and dies” based on health care organizations’ experiences with the surveyors. The surveyors need to be well qualified, well trained and consistent. Towards that goal, JCAHO is trying to limit the subjectiveness and bias currently involved in the survey process. Having surveyors utilize facility specific data and information to cus-

tomize the on-site survey process is one model for achieving such a goal.

A discussion regarding the duplication in efforts amongst JCAHO and NCQA and other regulatory bodies was also identified as a drain on limited resources and energies for smaller health care organizations. **A preference for NCQA’s focus on outcomes in comparison to JCAHO’s comparison on process was expressed by several speakers.** Mr. Cappiello briefly commented on the Performance Measurement Council; the formal (and yet unproven) collaboration of JCAHO, NCQA and the AMA to such concerns.

The cost and complexity of the JCAHO survey process for diversified rural health care organizations was also discussed. Examples of JCAHO surveyors struggling to overlay hospital-based standards on physician clinics and home care agencies during recent surveys were shared. Other administrators commented on the frustrations of having JCAHO surveys focus on diverse priorities each 3 year cycle. The cost and complexity of developing systems to support the shifts in focus between survey cycles does not appear to add any value to the quality of health care provided by the surveyed organizations.

Although the problematic issues identified were not resolved by the end of the discussion, the dialogue was felt to be a healthy exercise and Mr. Cappiello encouraged the RWHC board to invite him back for future discussions. The Board, in turn, strongly encouraged Mr. Cappiello to consider the concerns shared during the discussions as improvement initiatives are prioritized.

MD Barriers To Using Clinical Guidelines

From “Why Don’t Physicians Follow Clinical Practice Guidelines? A Framework for Improvement” by Michael D. Cabana, MD, MPH et al in *JAMA*, 10/20/99:

“Physician adherence is critical in translating recommendations into improved outcomes. However, a variety of barriers undermine this process. Lack of awareness and lack of familiarity affect physician knowledge of a guideline. In terms of physician attitudes, lack of agreement, self-efficacy, outcome expectancy, and the inertia of previous practice are also potential barriers. Despite adequate knowledge and attitudes, external barriers can affect a physician’s ability to execute recommendations.”

Internal Barriers

“Lack of Awareness The expanding body of research makes it difficult for any physician to be aware of every applicable guideline and critically apply it. Although many guidelines have achieved wide awareness (i.e., immunization guidelines, recommendations for infant

sleeping position), for 78% of the guidelines, more than 10% of physicians are not aware of their existence.”

“Lack of Familiarity Casual awareness does not guarantee familiarity of guideline recommendations and the ability to apply them correctly. Of 74 surveys that measured guideline awareness or familiarity, only 3 (4%) also measured both. In all cases, lack of familiarity was more common than lack of awareness.”

“Lack of Agreement Physicians may not agree with a specific guideline or the concept of guidelines in general. Although physicians commonly indicate a lack of agreement when asked about guidelines in theory, from this analysis and others, when asked about specific guidelines, physician lack of agreement is less common. The results of studies that examine physician attitudes to guidelines in general should be interpreted with caution when applied to specific guidelines.”

“Lack of Self-efficacy Self-efficacy is the belief that one can actually perform a behavior. It influences whether a behavior will be initiated and sustained despite poor outcomes. For example, higher self-efficacy in prescribing cholesterol-lowering medications was associated with physicians initiating therapy consistent with national guidelines. Low self-efficacy due to a lack of confidence in ability or a lack of preparation may lead to poor adherence. Sixty-eight percent of the surveys that reported this barrier involved preventive health education and counseling, which suggests that poor self-efficacy may be a common barrier to adherence for such guidelines.”

“Lack of Outcome Expectancy Outcome expectancy is the expectation that a given behavior will lead to a particular consequence. If a physician believes that a recommendation will not lead to an improved outcome, the physician will be less likely to adhere. For example, the USPSTF recommends that physicians provide smoking cessation counseling. Although most physicians are aware of and agree with the recommendation many smokers are not counseled to quit during a physician visit. An important reason for physician nonadherence is a belief that the physician will not succeed.”

“Inertia of Previous Practice Physicians may not be able to overcome the inertia of previous practice, or they may not have the motivation to change. Although this barrier has not been investigated as widely as others, for all 14 surveys that examined this barrier, more than 20% of respondents indicated that it was a barrier to adherence.”

External Barriers

“Appropriate knowledge and attitudes are necessary but not sufficient for adherence. A physician may still encounter barriers that limit his/her ability to perform the recommended behavior due to patient, guideline, or environmental factors.”

“External barriers that limit the ability to perform a recommended behavior are distinct from lack of self-efficacy. For example, well-trained physicians confident about their counseling skills can still be affected by external barriers (time limitations, lack of a reminder system) that prevent them from adhering to a counseling guideline. However, the persistence of these barriers may also eventually affect physicians' self-efficacy, outcome expectancy, or motivation.”

“Guideline-Related Barriers Physicians were more likely to describe guidelines as not easy to use or not convenient when asked about guidelines in theory. When physicians were asked about barriers for specific guidelines, a significant percentage (more than 10% of respondents) described them as inconvenient or difficult to use in only 6 (38%) of 16 cases.”

“Patient-Related Barriers The inability to reconcile patient preferences with guideline recommendations is a barrier to adherence. Patients may be resistant or perceive no need for guideline recommendations. In addition, a patient may perceive the recommendation as offensive or embarrassing. In all the surveys that included patient-related factors, more than 10% of physicians indicated them as a barrier to adherence.”

“Environmental-Related Barriers Adherence to practice guidelines may require changes not under physician control, such as acquisition of new resources or facilities. For example, unavailability of an anesthesiologist 24 hours a day may interfere with physician ability to adhere to guidelines aimed at decreasing the rate of elective cesarean deliveries. Many factors described as barriers by more than 10% of respondents, such as lack of a reminder system, lack of counseling materials, insufficient staff or consultant support, poor reimbursement, increased practice costs, and increased liability, may also be factors beyond physician control.”

For Colds/Flu, TLC Is Often The Prescription

From “There's No Excuse for Antibiotic Overuse!” by The Alliance at www.alliancehealthcoop.com/ “

“It's that time of year when everyone seems to be getting sick. Colds, the flu, ear infections-you name it, somebody has some type of upper respiratory illness. One morning your child wakes up with a slight fever, a stuffed-up nose, and a cough. You take her to the doctor, expecting an antibiotic. The doctor tells you that antibiotics aren't always the answer. Why? Many common upper respiratory illnesses-like colds, the flu, and most coughs and bronchitis-are caused by viruses. What's the best cure for a virus? Time. Our bodies fight off most viruses in 1-2 weeks without help from medicines. Antibiotics won't help your child get better when he has a virus, because antibiotics don't kill viruses.”

You can help your child feel better by:

- Making sure your child gets plenty of rest,
- Giving saltwater nose drops 4-5 times per day
- Raising the head of the crib/bed 4-6 inches
- Giving plenty of fluids--hot soups, water, or juices
- Using acetaminophen or ibuprofen for fever or pain”

“But, viruses aren't the only germs that can make your child sick. Some upper respiratory illnesses-like strep throat, many ear infections, and sinus infections-are caused by bacteria. Antibiotics help your child get well when she has a bacterial infection, because antibiotics kill bacteria. It's really important to use antibiotics only for bacteria. Why? Doctors have learned that when antibiotics are overused, bacterial germs can develop ways to fight off the medicine. These germs are called "antibiotic-resistant bacteria" or "superbugs." "Superbugs" can make illnesses harder to cure and last longer. They can also be spread to your friends and family. Because "superbugs" are becoming more common, doctors need to be much more careful about how they use antibiotics. You can help prevent antibiotic overuse by talking with your doctor about the best way to treat your child's illness.”

Ask:

- “Is my child's illness caused by a virus or bacteria?”
- What can I do at home to help my child feel better?”
- When should my child feel better?”
- When should I call your office or come back in if he's not getting better?”

“Together, you and your doctor can help your child get back on his feet as soon as possible.”

10 Steps To Increase BadgerCare Enrollment

The following is from Tom Pyne, Vice President Public Policy & Mission Services, Catholic Health Association of Wisconsin (CHAW):

1. Contact your County/Tribal Social or Human Services Department or your local W-2 agency. Ask about their CARES data system – the Client Assistance for Reemployment and Economic Support data system. CARES is used by county income maintenance workers to determine eligibility for a number of public assistance programs, including W-2, food stamps and medical assistance (MA). CARES has the capacity to identify family members of current Medical Assistance (MA) recipients and also tabulate the number of siblings and parents who are in families with a child enrolled in MA. The majority of siblings and parents of children enrolled in MA are eligible for BadgerCare.

2. Contact the local Public School System(s) to ask about their “Free and Reduced Income

School Lunch Program.” The school system will have a database of names, phone numbers and addresses. Perhaps in partnership with the hospital, do a mailing to those families.

3. Form a coalition of community organizations to enlist their support to “get the word out” about BadgerCare at the places where people gather. Engage the community at-large in outreach and enrollment activity.

- | | |
|---|---|
| <input type="checkbox"/> local churches | <input type="checkbox"/> parish nurses |
| <input type="checkbox"/> food bank | <input type="checkbox"/> social service agencies |
| <input type="checkbox"/> advocacy groups | <input type="checkbox"/> local hotel managers |
| <input type="checkbox"/> supermarkets | <input type="checkbox"/> chain discount stores |
| <input type="checkbox"/> child care centers | <input type="checkbox"/> Head Start center |
| <input type="checkbox"/> school nurses | <input type="checkbox"/> tax preparers' offices |
| <input type="checkbox"/> area pharmacies | <input type="checkbox"/> physician office personnel |
| <input type="checkbox"/> local librarian | <input type="checkbox"/> local news media |

4. Invite a county representative to the coalition to make a presentation on BadgerCare. Educate for effective outreach. Create awareness of the program and the process and enlist their support.

5. Distribute BadgerCare brochures and posters throughout your facilities. Call CHA-W (608-274-5588) if you need additional brochures or posters and we will send you an order form and other contact information; publicize BadgerCare in your newsletters.

6. Sponsor a series of advertisements in the local newspaper. Be sure to include the toll free number for BadgerCare 1-800-362-3002 in the advertisements.

7. Invite your hospital volunteers to become community outreach volunteers. BadgerCare will enable uninsured children of the working poor to obtain medical care without having to depend on charity.

8. Review your bad debt and charity cases. Some of these former patients may be eligible for BadgerCare. Consider doing a mailing to them on BadgerCare.

9. Develop a one-page insert on BadgerCare as a payroll stuffer. Many entry level employees may be eligible for BadgerCare.

10. Sponsor a mailing to small employers through the Chamber of Commerce. Enlist local businesses and ask them to distribute flyers to their employees and to their customers.

No Ifs or Buts, Get the Yellow Book Update

Ten years ago, the U.S. Office of Technology Assessment published *Health Care in Rural America*, popularly know as “that large yellow book”--an encyclopedia

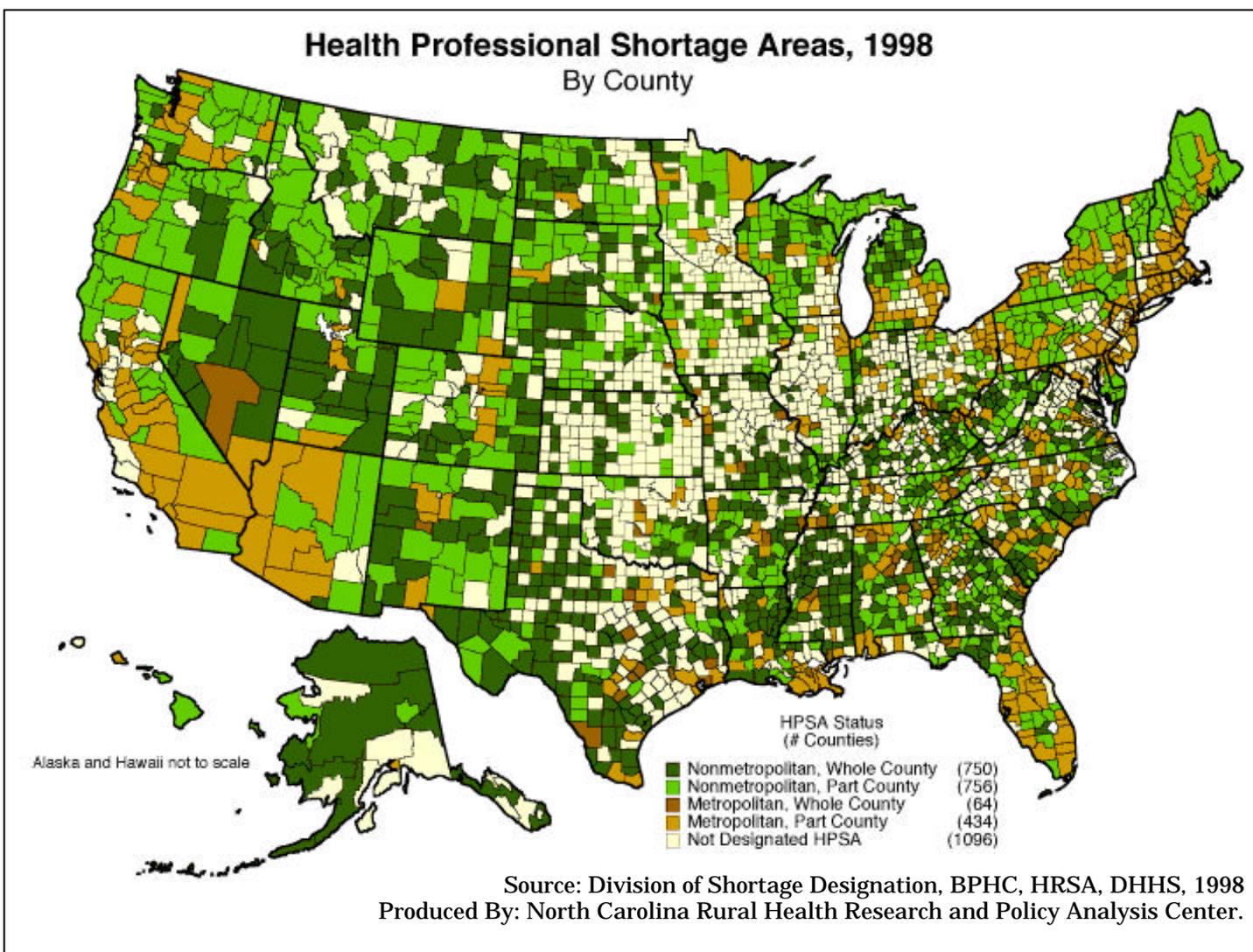
of rural health facts, programs and policy issues. The federal Office of Rural Health Policy has now sponsored the development of a long needed update, *Rural Health in the United States*. This is the only book which I know which can truly serve as a current, comprehensive guide for someone new to rural health policy or administration as well as a single ready reference for older folks.

While a terrific resource and required reading for all of us, by its goal of being comprehensive, it will disappoint readers looking for a substantial and indepth treatment on any one particular topic. But readers will find extensive references at the end of each chapter which should lead them to materials which drill down more deeply into any one topic.

It is available from your local book store or www.amazon.com (\$39.95 paper, \$60.00 hardcover).

The following is from the Introduction written by the book's editor, Tom Ricketts, director of the North Carolina Rural Health Research and Policy Analysis Center --an incredibly concise and powerful statement about rural health and the role of rural health policy.

“When confronted with the realities of the size and scope of the rural population in the United States, it is hard to think of these 61 million people as a disadvantaged group. Their numbers exceed the total population of many nations, including Great Britain, France, Spain, and Italy. Yet, in many ways, but specifically in health care access, rural Americans are distinctly disadvantaged. Rural Americans make up 20% of the nation's population, but only 9% of the nation's physicians practice in rural counties. Medicare beneficiaries in non-metropolitan counties receive 15% less in the way of all physician services and a striking 40% less in cardiology. Rural patients see doctors less often and usually later in the course of an illness. When a person living in a rural area goes into the hospital, it is usually for a longer stay even though the hospital will be paid less for that patient if the hospital is located in a rural area. This pattern evolved early in this century and despite major efforts to change the distribution of resources, rural communities lag well behind their city cousins in health care. The U.S. Congress, state legislatures, and regional governments recognize this disparity but the solution to the imbalances continues to elude them.”



"The facts of this disparity between rural and urban remain and this book is intended to bring those facts once again to the attention of the people who can make a difference in policies. *Rural Health in the United States* is also meant to inform rural communities themselves, to provide them with the information they need to effectively argue for change. Facts, data and statistics cannot create solutions: They must be turned into information on which arguments can be based and comparisons drawn to support options that are favorable for change. This book is designed to take data and turn them into information that can be used to create the policies that help Americans--especially rural Americans--build a better and more effective health care delivery system."

RWHC Hospital Wins Major Quality Award

From "Local hospital earns state award" in the Baraboo News Republic, 11/17/99:

"Gov. Tommy Thompson has announced that St. Clare Hospital and Health Services of Baraboo is one of 12 companies to receive the Wisconsin Forward Award, recognizing world-class quality performance among Wisconsin employers. Thompson said organizations like St. Clare help produce and maintain Wisconsin's skilled work force. Award recipients were honored at the second annual Wisconsin Forward Awards ceremony at the Monona Terrace and Convention Center."

"'St. Clare's mission and vision, supported by continuous quality improvement, provides the foundation for meeting the various challenges presented by its changing industry and community,' Thompson said. 'Its quality management principles guide management of all enterprise activities.'"

"St. Clare's performance management system includes integration of a strong customer focus throughout its strategic planning and other management systems, use of employee work teams in implementing its Continuous Quality Improvement Model, and extensive use of benchmarking to identify best practices."

"The Wisconsin Forward Award is an annual recognition and award program modeled after the Malcolm Baldrige National Quality Award. Its mission is to promote world-class standards of management excellence. The Award process challenges businesses, educational institutions, health care providers, governmental agencies and other nonprofit organizations to advance their competitive position and achieve world-class status in the global marketplace, promote continuous learning and performance improvement and identify organizational strengths and target key opportunities for improvement."

Dean of Rural Hospital CEOs Honored

From "Harold Brown honored by Chamber" by Kelli Boylen in the Prairie du Chien *Courier Press*, 10/13/99:

"Harold Brown, CEO of Prairie du Chien memorial Hospital, received the Prairie du Chien Chamber of Commerce's highest award during the annual meeting Monday night."

"Part of Harold's vision of a successful community hospital included serving people through expanded community services. Over the years Prairie du Chien hospital was the first rural hospital to develop a structured hospice program, build an assisted living facility and to partner with the state to start a Family Resource Center."

"One of the first rural hospitals in the state to provide elderly and child care and respite care, and to start a Parish Nursing program. An early developer of community programs such as elderly meals on wheels, county prisoner meals and laundry and community rehabilitation programs, public school athletic training and the CARE Council drug awareness program for teens."

"Harold's economic success and community health care vision has made him known and respected on a state and national level. Prairie du Chien Memorial Hospital is now known nationally as a model for community hospitals." (Prominently noted in *Rural Health in the United States* reviewed in this newsletter issue.) In addition to his numerous accomplishments (including \$760,000 in uncompensated care to the community last year), Harold's most important attribute is that he sincerely cares about the people of this area, and strives to serve them as best he can in everything he does."

