

Review & Commentary on Health Policy Issues from a Rural Perspective - February 1st, 2001

Fair Medicare Payments Are Not Subsidies

When we speak the same language we assume we are communicating—big mistake. After twenty years of advocating for fairer Medicare payments to rural providers I have come to realize that we still suffer from a profound failure to communicate. (So much for my communication skills.) The different words we choose, and related differences in the assumptions behind them, significantly complicate working relationships between we in the field and those folks responsible for managing the Medicare Trust Fund.

Last year I was at a meeting with representatives of the Health Care Financing Administration. The stated purpose was to improve communication with a number of invited guests from the Mid-West. The mood began cordially and oriented towards collaboration. Then, at least for me, the sense of a potential shared purpose suddenly evaporated.

A HCFA spokesperson who clearly cared for rural issues spoke of the need for higher rural “subsidies.” To the surprise of us both, I reacted very negatively to her call for subsidies. For me the word “subsidy” brought up very inappropriate imagery—something like “rural petitioners, hat in hand, eyes down cast, dependant upon the unearned charity of the federal government.”

If this was just about my own feelings, I would get over it. But since then I have come to understand that there is something more important at play. Let me be very clear, I am not against subsidies, grants or gifts. The government has an affirmative responsibility to bring

health care to those not receiving it and use subsidies as appropriate.

But we must distinguish between advocacy for subsidies and advocacy for payment equity which derives from the Federal government’s statutory obligation to Medicare beneficiaries. **If we allow demands for payment equity to be characterized as a request for a subsidy, we unnecessarily take on the burden of proof to show why fair payment is necessary; the burden of proof belongs to HCFA to either justify the current system of inequitable payments or change the system.**



When a subsidy is requested, the responsibility to be persuasive lies with the applicant. Providers asking for a grant understand and accept that there is competition for limited funds and that a case needs to be made for the unusual need of the situation, of a justification for special treatment.

A request for fair payment is just the opposite of a request for a subsidy; it is a claim to not receive special treatment; it is a claim for equitable, consistent treatment. For rural providers, this means they expect to receive, at a minimum, the same pay for the same service elsewhere provided

Medicare beneficiaries.

The basis for rural hospitals’ claim for better reimbursement lies in the government data showing that they are paid less than urban hospitals for the same service while ironically being forced to subsidize, on average 6.4%, the cost of providing services to Medicare beneficiaries. In comparison, urban hospitals make a small profit (1.9%) on Medicare inpatient services. (MedPAC, 2000) **Providers must claim fair Medicare payment, not subsidies, for their work.**

Improving Quality No Longer Just Academic

From "Outlook 2001: Quality Issues Grab Attention,"
by Ed Lovern, *Modern Healthcare*, 1/1/01:

"Healthcare quality guru Don Berwick, M.D., likened the shortcomings in healthcare quality to the dark villain in the popular Harry Potter novels whose name most are afraid to say out loud. 'Well, I'm not afraid to say his name,' Berwick bravely told 3,000 attendees of the National Forum on Quality Improvement in Health Care last month in San Francisco. Everyone else with a stake in healthcare also seems to have gathered the courage to shout Voldemort's name. Healthcare quality has attracted almost as much attention in the past few months as the release of J.K. Rowling's fifth novel. Among the developments:"

"The Institute of Medicine is releasing a second report on healthcare quality in January or February. IOM committee member and Harvard professor Lucian Leape, M.D., says the new report will 'call for an overhaul of the healthcare system and how to do it.' The new document will be broader than the IOM's 1999 report on medical errors, which estimated that as

Wisconsin's 4th Annual Rural Health Conference

April 26th and 27th in Mosinee. Among other
Keynotes: Marcia Brand, Director, Federal
Office of Rural Health Policy & Wisconsin's own national
television personality, Dr. Zorba Paster.
For details, email: bduerst@facstaff.wisc.edu

many as 98,000 people die in hospitals each year as a result of medical errors."

"The Leapfrog Group, a consortium of 60 employers providing health benefits for more than 20 million Americans, initiated a plan in November to purchase healthcare from providers that meet their specific quality expectations."

"The Joint Commission on Accreditation of Healthcare Organizations is expected to implement its first set of standards dealing directly with patient safety in hospitals in July."

"HCFA's first national Medicare quality-of-care study released in October ranked states from best to worst and brought attention to the tremendous variation among providers in adhering to clinical best practices." (WI ranked 11th.)

"The patient safety budget for the Agency for Healthcare Research and Quality -- the federal government's agency for patient safety research -- is expected to jump to as high as \$50 million in 2001 from \$4 million in 2000."

"A consumer study released in December shows that Americans are beginning to place more importance on standardized quality measures in selecting healthcare providers."

"The energy around quality issues represents nothing less than a ground swell that healthcare providers will be forced to reckon with in the coming year."

"The situation represents a dilemma for health system chief executives, some of whom confide that re-vamping their organizations to make substantial improvements in quality of care requires resources and energy already soaked up by a plateful of competing priorities."

"Also complicating efforts to improve -- or even maintain -- quality of care is that we are in the midst of a nursing shortage which, unlike previous staffing crunches, has no end in sight. Fewer people are entering the nursing profession, the average age of nurses in the field continues to climb and all this is occurring on the brink of increased demand for healthcare services from the aging baby boomer population."

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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

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Individual Blindness To System Failure

From “A Founder of Quality Assessment Encounters A Troubled System Firsthand” by Fitzhugh Mullan in *Health Affairs*, Jan-Feb, 2001

“Shortly before his death, Avedis Donabedian talked with Fitzhugh Mullan about health care and the management of his own cancer care. Donabedian, physician, scholar, and poet, died on 9 November 2000 at age eighty-one, a month after this conversation with Mullan. Known fondly by his students as ‘Mr. Structure-Process-Outcome’ and internationally for his ‘,’ Donabedian through his research and writing created much of the conceptual underpinnings for quality assessment in health systems used today.”

“**Mullan:** You have certainly been a patient of the system. But for many years you have also been a physician, commentator, and philosopher of the system. What stands out in your mind about medical care as you’ve experienced it?”

“**Donabedian:** Where should I begin, my friend? I would say that my view is generally positive. I have tried to choose doctors who work together reasonably well, so that there is some degree of communication and continuity. Still, there are areas where no one takes responsibility, where planning is weak, where I am left on my own. I have a primary care physician who visits me regularly, and this helps. But at a university hospital, residents from the different services control most things, and their coordination is not always good. And the nursing staff is very friendly. They give me hugs and kisses.”

“**Mullan:** You’ve written a great deal about quality of care, for instance, your principles known as Donabedian’s Seven Pillars of Quality. How do you feel about the quality of care you’ve received?”

“**Donabedian:** The view of quality that is taken in the hospital is really limited to technical competence and, more recently, to superficial attention to the interpersonal process. Keep the patient happy, be nice to the patient, call him Mr. or Mrs., remember his name. The idea that patients should be involved in their care is not really practiced in a responsible way. Today people talk about patient auton-

omy, but often it gets translated into patient abandonment. The doctor has to work diligently with the patient to arrive at a solution that is ultimately acceptable to the patient but is not entirely undirected. The role of the doctor is to actively make sure that the patient arrives at a decision that is a reasonable one for him or her, without being manipulative.”

“**Mullan:** In your experience, do systems of care work the way they are supposed to?”

“**Donabedian:** People have a big problem understanding the relationship between quality and systems. Many doctors seek refuge in the allegation that they are good clinicians but the system is wrong, without realizing that they are the key aspect of the system. The system is the responsibility of the doctors and the hospital leadership. The surgery outpatient clinic is an excellent and troubling example; it’s a place I have frequently waited for extended periods. I once asked one of the nurses why the wait was so long. She responded that they had to wait until the residents on the inpatient service finished their work and came to staff the outpatient clinic. Meanwhile, the patients wait. The system is the problem. The same thing happens in the geriatric outpatient clinic where, in theory, I am cared for by the same team of nurses at every visit. It never happens. A plan exists on paper, but the system doesn’t work. I see different people every time, and we start from scratch.”

Avedis Donabedian’s Seven Pillars of Quality

- Efficacy
- Effectiveness
- Efficiency
- Optimality
- Acceptability
- Legitimacy
- Equity

“**Mullan:** As hospital care becomes increasingly complex and intensive, it is clear that the lack of a well-honed system can easily lead to errors. What was your sense of confidence in the day-to-day management of your care in the hospital?”

“**Donabedian:** I think the hospital floors are a disaster. I saw so many part-time nurses working variable hours. They come and go. Often I couldn’t tell whether I was dealing with a nurse, a technician, an attending physician, or an attendant. I saw rampant discontinuity in nursing care and many poorly oriented nurses, especially on weekends. I had a young nurse assigned to me one day who clearly did not know how to handle a colostomy. “Do you know anything about colostomy management?” I asked her. “No,” she answered. “Okay, sit down. I’ll teach you.” She learned and thanked me profusely, but this was an unbelievable situation. Of course, there’s tremendous difference in the competence of nurses.

Some nurses make everything run like clockwork, while others are quite disengaged.”

“**Mullan:** During a recent stay in the hospital, I found myself checking to see who was going to be assigned to me the next shift. I was enormously relieved to see someone who had been there before and who knew me and my equipment.”

“**Donabedian:** What makes for clinical situations like this is failure to realize the relationship between what I have called structure, which can be called system design, and system performance. Things won’t improve until something is done about the design of the system.”

“**Mullan:** Why is this happening? The hospital leadership is not malevolent, and yet the system it has constructed is in many ways poor and occasionally dangerous.”

“**Donabedian:** I think poor training and education have a lot to do with it. System management doesn’t get taught in medical or nursing schools. Then you put doctors and nurses in charge of systems that are under constant short-term financial pressures. These pressures are real, but the purpose of good systems is to deal with them.”

“The problem stems from a bit of myopia mixed with ignorance. It’s easy to train people to use a certain vocabulary—for instance, calling people “customers” to whom we offer “products”—but this doesn’t really change the culture or the awareness of the clinicians. Our clinicians should be able to spot weaknesses and bring them to the attention of the people who can fix them, but that doesn’t happen. There’s lip service to quality and, goodness knows, propaganda, but real commitment is in short supply.”

“**Mullan:** We have all experienced the rapid commercialization of health care in recent years. How do you feel about this?”

“**Donabedian:** I have never been convinced that competition by itself will improve the efficiency or the effectiveness of care or even that it will reduce the cost of care. I think that commercialization of care is a big mistake. Health care is a sacred mission. It is a moral enterprise and a scientific enterprise but not fundamentally a commercial one. We are not selling a product. We don’t have a consumer who understands everything and makes rational choices—and I include myself here. Doctors and nurses are stewards of something precious. Their work is a kind of vocation rather than simply a job; commercial values don’t really capture what they do for patients and for society

RWHC Eye On Health



“I appreciate you are both doing your best work but the total picture isn’t quite coming together.”

as a whole. Systems awareness and systems design are important for health professionals but are not enough. They are enabling mechanisms only. It is the ethical dimension of individuals that is essential to a system’s success. Ultimately, the secret of quality is love. You have to love your patient, you have to love your profession, you have to love your God. If you have love, you can then work backward to monitor and improve the system. Commercialism should not be a principal force in the system. That people should make money by investing in health care without actually being providers of health care seems somewhat perverse, like a kind of racketeering.”

“**Mullan:** How do you feel about the HMO movement?”

“**Donabedian:** I have always been strongly in favor of prepaid group practice as a way of providing medical care, reducing access barriers, and increasing fairness in the distribution of services. Managed care promised a more coherent, integrated, and coordinated way to provide care. Many of the structural features in today’s HMOs (health maintenance organizations) are those for which I advocated very strongly from the beginning. But there was always the proviso that HMOs would be designed with the objective of improving care, not reducing costs. There is nothing wrong with pursuing efficiency, but cost cutting alone does not produce efficiency and certainly does not improve patient care. HMOs today are good at measuring costs but pay little attention to measuring effects. This failure to look at outcomes undercuts all of the reasons that so many of us were interested in the prepaid group practice model to begin with. Even today I would be enthusiastic about HMOs if the financial pressures on doctors were removed. The challenge is to keep some

control over costs without creating a conflict of interest for physicians by tying their reimbursements to cutting patient costs. My solution would be built on the moral and scientific probity of the practitioner rather than on financial incentives and disincentives.”

“**Mullan:** As you reflect on the state of our health care system, including its commercial aspects and its huge continuing disparities in access to care, where do you see us headed?”

“**Donabedian:** I worry about my colleagues, the doctors. I’m a doctor, my son is a doctor, and my father was a doctor—a country practitioner in the villages of Arab Palestine and my model for what a good physician should be. I worry about the fate of the medical profession because physicians are babes in the woods. Over the years, doctors haven’t trusted government. They fought every proposed reform—national health insurance under Harry Truman, Medicare under Lyndon Johnson, and most recently, health care reform under Bill Clinton. Now market capitalism has taken over, and doctors are being exploited left and right by corporate enterprise. They’re gradually losing the respect of the public. I worry about the health care profession developing a kind of technician status and attracting only second rate people. One positive aspect of the current chaos is that it is generating dissatisfaction on all sides. Sooner rather than later we are going to have to develop a national health plan. The design and implementation of such a plan will be an exciting task of the fairly near future, I believe. This country has tremendous wisdom and tremendous goodness. Eventually they will triumph in health care.”

“...cost cutting alone does not produce efficiency and certainly does not improve patient care. HMOs today are good at measuring costs but pay little attention to measuring effects.”

plenty of painkilling medication, and no heroic attempts to prolong her life. In short, she died much as her grandmother and great-grandmother might have: at home.”

“As painful as it was for Joyce’s family, they now tell of countless moments rich with meaning and affection. ‘Once you admit that someone is dying, it becomes such valuable time,’ says her daughter, Nancy Kerr Akbari, M.D., a resident at Mount Sinai Medical Center in New York City. ‘You’re feeling everything, saying everything. I was really grateful we got to do that with her.’”

“The Kerrs’ experience, unfortunately, is not typical. ‘We don’t die well in America,’ says journalist Bill Moyers, whose mother died in April 1999, after what he calls ‘three long, hard years’ of illness. ‘People say they want a natural death in familiar surroundings,

with some choice and control over the circumstances. Too often, they don’t get it.’”

“Ninety percent of adult Americans say they would prefer to die at home; 80 percent die in hospitals or nursing homes. More often than not, they die in pain, despite the availability of painkillers. Only 15 percent to 20 percent of Americans have obtained advance directives, the legal documents that specify what kind of care they do and don’t want in critical medical situations. Even when the documents exist, relatives and doctors often ignore or overrule them. And only a small fraction of the terminally ill have access to hospice care, which focuses on comfort and support of the patient and family rather than on curative treatments.”

“Moyers chronicled Joyce Kerr and more than a dozen others for his four-part PBS documentary, *On Our Own Terms: Moyers on Dying*. He hopes the series will spark discussion and action to enhance the end-of-life experience. On his list of priorities: better medical training for those who treat the dying, better pay for caregivers, and improved Medicare coverage for out-of-hospital costs. Most important, Moyers hopes Americans will think carefully about what they want as they die, and encourage family members to do the same. ‘Love involves loss,’ he says. ‘We have to realize that and prepare for it.’”

For resources on aging and end-of-life care, visit <<http://www.pbs.org/onourown/terms>>.

Living Is Also About Preparing For Loss

From “The Good Goodbye,” *Good Housekeeping*, 9/00:

“Joyce Kerr was, by all accounts, a remarkable woman—a former teacher, full of life and love, selflessly devoted to her husband, Bill, and their four children. And she had a remarkable death.”

“Joyce, 65 years old, fought ovarian cancer for two years. When she died in May 1999, it wasn’t in a hospital, with a harried medical staff, high-tech machines, and one or two roommates. She died in her beloved New Jersey house, with family around her,

End Of Life Care Principles

The following is from “Principles for Care of Patients at the End of Life: An Emerging Consensus among the Specialties of Medicine” By Christine K. Cassel and Kathleen M. Foley, 12/99 as published by the Milbank Memorial Fund at <www.milbank.org/endoflife/>.

To date, the following organizations have formally adopted the Core Principles exactly as written: the American Medical Association, Academy of Psychosomatic Medicine, American Academy of Hospice and Palliative Medicine, American Board of Hospice and Palliative Medicine, American College of Chest Physicians, American Pain Society, and the National Kidney Foundation.

Core Principles for End-of-Life Care

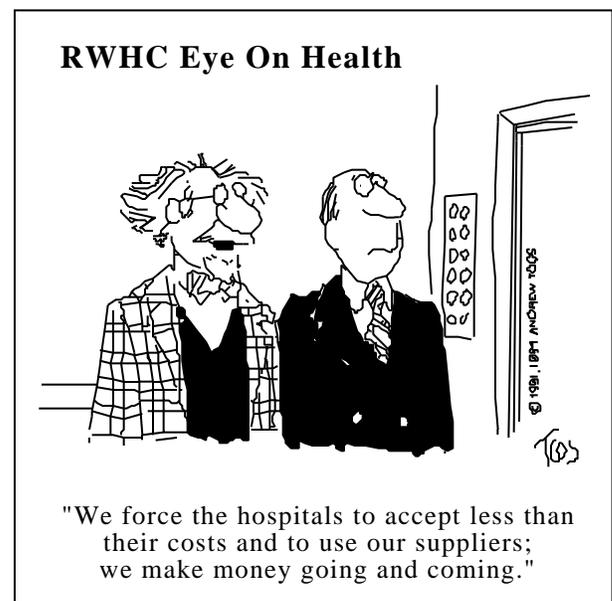
“Clinical policy of care at the end of life and the professional practice it guides should:

1. Respect the dignity of both patient and caregivers;
2. Be sensitive to and respectful of the patient's and family's wishes;
3. Use the most appropriate measures that are consistent with patient choices;
4. Encompass alleviation of pain and other physical symptoms;
5. Assess and manage psychological, social, and spiritual/religious problems;
6. Offer continuity (the patient should be able to continue to be cared for, if so desired, by his/her primary care and specialist providers);
7. Provide access to any therapy which may realistically be expected to improve the patient's quality of life, including alternative or nontraditional treatments;
8. Provide access to palliative care and hospice care;
9. Respect the right to refuse treatment;
10. Respect the physician's professional responsibility to discontinue some treatments when appropriate, with consideration for both patient and family preferences;
11. Promote clinical and evidence-based research on providing care at the end of life.”

Competitive Threat To Rural Infrastructure

The following is from a recent letter from rural providers to local employers in part of the RWHC service area. Names have been deleted to protect both the innocent and the guilty as this story could easily come next to a county near you and needs to be understood in the broader context:

“A ‘Health Plan’ in the RWHC service area has announced that as of January 1, 2001, it will no longer pay for most laboratory tests which are currently done in local hospitals and clinics. Instead they will send the lab work to Milwaukee causing patients and physicians to have to wait for the test results. This announcement has prompted us to write this letter.”



“The ‘Health Plan’ referred to ‘financial considerations’ to explain its decision to ship out lab work to Milwaukee. But the real story is . . . the average charge per lab test by hospitals and clinics actually decreased this year while the Insurer’s premiums are increasing 30% to 60% for many rural employers.”

“Now consider the impact this decision will have on the quality of patient care in just one county. The ‘Health Plan’ says it will have test results available in 24 hours. Currently, results of most tests performed by local hospitals and clinics are available within a few hours and in some cases as little as 30 minutes. Because lab test results can either confirm or rule out what your doctor suspects is wrong with you, a delay in getting the results can postpone the start of your treatment. Also consider that if the hospital or clinic should miss the courier taking blood and specimens to

Milwaukee, the turnaround time would be as long as 48 hours. Next, consider the impact this decision will have in our County:

- The Rural Wisconsin Health Cooperative estimates that the action taken by the 'Health Plan' will cause our County's providers to lose revenue in excess of \$480,000. Those dollars will go to Milwaukee.
- This 'Health Plan' may only be the beginning. If the other Plans with membership in the county follow suit, the lost revenue by local providers would be \$2.1 million annually.
- Hospitals and clinics must remain competitive in the market by offering salaries and benefits to attract and retain qualified personnel. By shifting services out of the County, the strain on local providers to maintain their high quality workforce will grow.
- A study recently conducted by the University of Wisconsin-Extension shows that for every two healthcare dollars generated by healthcare providers, an additional dollar is generated within the County. The reverse is true – when two dollars in healthcare revenue leaves the County, so does one non-healthcare dollar."

"We urge you to consider these points, as they greatly impact our community as well as your employees. Look for us to address these issues at upcoming community meetings."

Rural Hospital Gets Governor's Top Award

St. Clare Hospital & Health Services, a RWHC member, has been awarded the 2000 Governor's Forward Award of Excellence.

The Governor's Award of Excellence is presented to organizations at the highest achievement level possible under the Wisconsin Forward Award. Governor Tommy Thompson created the award program in 1997 to promote and recognize organizational excellence in business, government, service, education and healthcare.

St. Clare is one of only two hospitals in Wisconsin to ever win this prestigious award which is open to all sectors of business and industry in the State.

The Governor presented the award to St. Clare President Dave Jordahl at a ceremony and banquet held at the Monona Terrace in Madison. In his remarks Governor Thompson said that St. Clare Hospital & Health Services and other recognized businesses and organizations "help ensure that Wisconsin will continue to lead the nation in creating and maintaining great jobs and building a bright future for our state's citizens and communities." The Governor urged Wisconsin businesses to use the Wisconsin Forward Award process to further improve Wisconsin's competitive edge.

Jordahl said that the health care industry tends to focus its attention on price, reimbursement and cost reductions while quality is either assumed or taken for granted.

"If you look at the typical measures of success that most hospitals share," Jordahl said, "you see that the emphasis is on financial performance. At St. Clare, we've always focused our attention on quality improvement as the best way to gain the trust of the communities we serve, prove our value and gain a competitive edge. Achieving the Governor's Forward Award of Excellence thrills us because it serves to validate and acknowledge our decade-long quality journey and speaks volumes about the loving care and service we give to our customers."

Wisconsin Forward Award uses the internationally recognized Malcom Baldrige Criteria for Performance Excellence to assess and recognize performance excellence and customer-focused quality and continuous improvement of the businesses that apply for the award. The seven criteria are leadership; strategy development; focus on patients, other customers, and markets; use and analysis of information; employee relationships; process management; and performance results.

For more information, visit the Forward Award website at <<http://www.forwardaward.org>> and St. Clare's site at <<http://www.stclare.com>>.

WWW Information Re Rural Related Grants

State & Federal Funding (from WI Primary Care Assoc.):

<http://www.doa.state.wi.us/dhir/boir/wcca>

http://www.doa.state.wi.us/dhir/boir/fed_state

Telecommunications (from WI Office of Rural Health):

<http://www.ntia/doc.gov/otiahome/top/index.html>

<http://www.usda.gov/rus/elecom/dlt/dlt.htm>

\$1,000 Prize

For The School Year's Best Rural Health Essay

Hermes Monato, Jr. Memorial Fund

*Write on a rural health topic for one of your regular classes
and submit the same paper as an entry by April 15th.*

The Essay Prize, established in 1993, is **open to all students of the University of Wisconsin-Madison, who are associated with the Center for Health Sciences.** The competition was established in honor of the memory of Hermes Monato, Jr., a December 1990 graduate, as well as to highlight the University's growing understanding of the importance of rural health. Hermes, at the time of his death, worked at the Rural Wisconsin Health Cooperative's main office in Sauk City. His infectious spirit and creative mind left rural health with an enduring legacy.

The writer of the winning essay will receive a check for \$1,000 paid from a trust fund established at the University by RWHC, family and friends of Hermes. The deadline for submission of essays each year is April 15th; it need not have been written specifically for this prize. You may obtain an application form (very short) from the RWHC office.

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