

## Hippocrates to IOM: “First Do No Harm”

by Tim Size, RWHC Executive Director

From a press release by the Institute of Medicine (IOM) on June 2, “The Medicare program adjusts its baseline payments to hospitals and individual health care practitioners based on regional variations in expenses beyond providers’ control, such as rents, wages, and liability premiums. The goal is to ensure that payments are accurate and fair. *Geographic Adjustment in Medicare Payments*, a new report from the Institute of Medicine (IOM), assesses the methodology and data sources used to calculate payment adjustments and recommends ways to improve their accuracy. The report is the first of three examining Medicare’s geographic adjustment factors.” The complete report is available at [www.iom.edu/](http://www.iom.edu/)

“Although there is widespread agreement about the importance of providing accurate payments to providers, there is considerable and long-standing disagreement in the provider community and among policy makers about how best to adjust payments based on geographic location.”

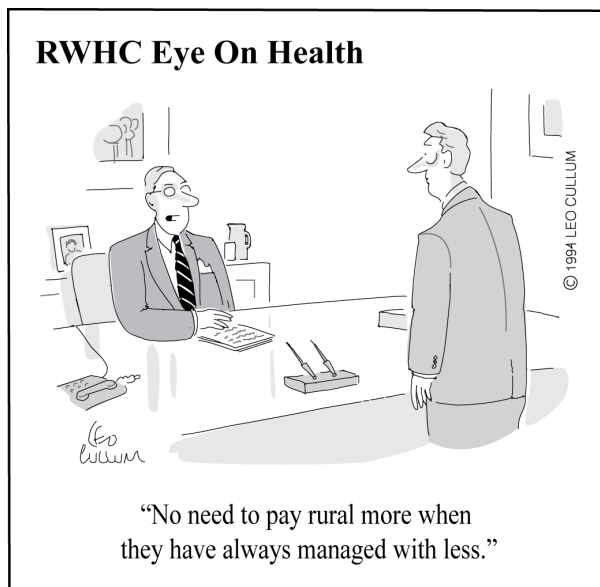
Count me as continuing to disagree. I believe the ancient Greek physician Hippocrates got it right when he told early physicians, to “first do no harm.” Thirty-four states have successfully petitioned Medicare

to treat all physicians in their state as serving the same geographic area. Now the IOM is proposing to fragment physicians and force rural physicians back into a single statewide payment bucket.

*Kaiser Health News* (6/3/11) noted one of the arguments being used for terminating statewide physician payment localities in states like Wisconsin. “Because of the payment system, doctors in many urban areas tend to be underpaid and some physicians in rural areas are overpaid, according to a 2007 report, “Geographic Areas Used to Adjust Physician Payments for Variation in Practice Costs Should Be Revised” by the Government Accountability Office (GAO).” Given the physician shortages rural communities have had and increasingly face, I believe that the five-year-old GAO report defines “overpayment” differently than rural communities would.

The IOM proposal may end up being used to increase urban practice income at the expense of rural practice income. In the name of “accuracy,” I am not willing to risk making it even harder to recruit physicians into rural communities. It seems to me that the chronic persistence of high rates of physician shortages in rural areas is all the argument one needs to contradict a feeling by some that rural physicians are over paid.

It should be noted that the American Academy of Family Practice is quoted in *Medscape* (6/3/11) as saying that they “would abandon geographic adjustments in favor of incentives such as a permanent,



meaningful, and direct bonus payment to physicians who work in underserved areas.” That may work well for physicians in officially designated underserved areas. It would be little comfort for those communities just a retirement or two away from being eligible for such designations needed to help level the playing field. As always, the “devil” would be in the details.

Surprisingly, *The New York Times* (6/3/11), gave voice to a concern from the heartland. “Michael D. Abrams, executive vice president of the Iowa Medical Society, said he was ‘a little surprised’ and disappointed that the panel did not acknowledge that Medicare overemphasized the importance of geographic differences in office rents. ‘You could argue that it costs more to deliver health care in rural America, in sparsely populated areas, than in densely populated areas,’ Mr. Abrams said. ‘Office space is a lot more expensive in Brooklyn, N.Y., than in Brooklyn, Iowa,’ he said, but Medicare’s payment formula gives too much weight to such differences.” These are the type of “boring” technical decisions that Medicare needs to make that in aggregate make or break rural health.

Potentially on the upside, the IOM proposes a smoothing of boundaries for hospital wage indices between urban Metropolitan Statistical Areas and rural non-Metropolitan Statistical Areas. These long notorious “wage cliffs” in Medicare reimbursement have no relationship to actual labor markets. Since

the beginning of the current Medicare payment system, this inequity has been cynically justified by some, saying every “model has its boundary problems.” This is easier to say if your own caregivers are on the uphill side of the cliff. We have the ability to smooth these differences and we should do it.

But unfortunately, the Committee did not have the time to apply the hospital cliff smoothing approach to their analysis of physician costs. It did say that such a technique could be adopted but did not make a specific recommendation. Hopefully they will do so in one of IOM’s two remaining reports in this series.

Any system that treats each Metropolitan Statistical Area as its own unique market but throws rural communities many hundreds of miles apart into one bucket, may be “scientific” but just doesn’t make sense.

When the IOM turns its attention to policy matters in its third report, I hope they address the fundamental circular dynamic that earlier federal policies have contributed to rural communities currently having fewer resources to pay physicians. The use of mathematics to sustain, and I assume unintentionally, long-term patterns of discrimination against rural communities would be a misuse of science.

Hopefully the IOM’s recommendations will not be interpreted by Medicare to mean that it can continue to pay rural less because it has always paid rural less.

My own bottom line for this first IOM report in the series is that throwing rural physicians into statewide rural buckets is a risky approach. Even if subsequent “add-on” payments are also recommended, they will be seen as an act of government “charity.” Such payments are needed in shortage areas to assure access for reasons that go beyond equitable payment to rural physicians for their work. Such payments should not be used to assure an equitable base payment rate for work done throughout rural America.

Supplemental payments are more vulnerable to be cut when budgets are tight. The base payment by Medicare to rural physicians must not be reduced due to data that reflects the effect of prior federal policy that undervalues rural health care. Equitable physician payments shouldn’t be left to federal “handouts.”

**Eye On Health** is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members to partner with others to make their communities healthier... generates additional revenue by services to non-Members... actively uses strategic alliances in pursuit of its Vision.

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## Medical Schools Can Make a Difference

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From “Patching the Rural Workforce Pipeline—Why Don’t We Do More?” by Jared Garrison-Jakel in *The Journal of Rural Health*, Spring 2011:

“The relative shortage of rural physicians is a persistent feature of American health care. Despite mid-century investment in expanding medical schools and recruiting international medical graduates, we have failed to fill the workforce gap. Simply increasing the number of physicians has proven an inefficient strategy for meeting rural health care needs. The central paradox of provider shortages remains that ‘The number of people living in designated health professional shortage areas has increased at the same time that the ratio of physicians to population has doubled.’ ”

“Moving into a new era of health care reform, the recruitment, training, and retention of rural health care practitioners continues to be a major challenge. In fact, access disparities facing America’s 61 million rural citizens are only likely to worsen. With only 3% of recent medical graduates planning to practice in small towns and rural areas, this unfortunate trend seems unlikely to abate without intervention.”

“To ensure the adequate supply of rural physicians, we must explore and utilize those factors predictive of subsequent rural practice among prospective medical students. For example, rural background and intent to practice family medicine have been demonstrated to strongly predict future rural practice. Those with both a rural background and an interest in family medicine on admission to medical school have a 36% likelihood of practicing in a rural region, compared to 29% of those with only a rural background and just 7% of those lacking both characteristics. In fact, in a prominent policy analysis, Geyman and associates stated that ‘increasing the number of physicians who grew up in rural areas is not only the most effective way to increase the number of rural physicians, but any policy that does not include this may be unsuccessful.’ ”

“In addition, the influence of the specialist-centered urban medical education and the concurrent deprivation of community-based training experiences are

important. We know that those exposed to nonurban clinical work during their medical training are 1.7 times as likely to choose rural practice. Yet student physicians routinely lack the structured opportunities to explore rural medicine that are necessary to counterbalance an educational system, favoring urban and suburban practice.”

“Despite calls to do so, medical schools have been slow to replicate such programs. In their Eighteenth Report, the Council on Graduate Medical Education (COGME) recommended that training institutions more aggressively pursue their social obligation to develop an adequate workforce, which they define as ‘one that is both sufficient in size and appropriately geographically dispersed such that most Americans do not experience an access problem.’ The report goes on to advocate that schools actively encourage graduates to practice in underserved areas.”

“Furthermore, COGME reinforced the **need to increase the admissions of students with rural backgrounds, challenging us to expand our conception of diversity to include geographic origin.** This is consistent with the Association of American Medical Colleges’ assertion that a diverse and sufficient workforce must not only reflect racial heterogeneity, but also the geographic and socioeconomic diversity of our nation. However, continued resistance prompted yet another COGME statement in May 2009, regarding the urgent need to realign graduate medical education with national health priorities.”

“So why have institutions of medical training proven reluctant? COGME suggests admission policies continue to favor privileged applicants likely to enhance institutional reputation among ranking agencies such as *US News & World Report*, in which the prestige of exclusivity is valued over the institution’s success in meeting national health care needs. Furthermore, concerns about admitting underprivileged rural applicants appear unjustified as the medical school performance of these students has not significantly differed from their class as a whole, despite lower admission test scores. The value placed on the current rankings is, clearly, to the detriment of the country’s most vulnerable communities, underscoring the need for an outcomes-based ranking system that is now either absent or poorly visible.”

**“Instead of asking what an applicant will bring to the institution, admission committees must turn their gaze outward and contemplate whom that applicant is likely to serve in his or her career. Reform must not be delayed. Our rural communities need physicians, and our medical institutions must embrace those policies known to nurture a workforce for this significant, neglected quintile of the American public.”**

## ACOs Urban Centric, Rural Models Needed

The following is from RWHC’s formal comments submitted to the Centers for Medicare & Medicaid Services (CMS) regarding Accountable Care Organizations (ACOs) on June 6. A copy of our complete set of comments is available at <[www.rwhc.com](http://www.rwhc.com)>.

“An ACO is an organization whose primary care providers are accountable for coordinating care for Medicare beneficiaries. Our view is that ACOs, as proposed by CMS, are fundamentally incompatible with rural health care’s need to maintain critical access to local health care. RWHC believes that CMS should rethink the concept of ACOs in rural communities. At the very least, CMS needs to develop ACOs that have a chance of working in rural communities.”

“We agree with CMS that ‘providers can work together to better coordinate care for patients, which can help improve health, improve the quality of care, and lower costs.’ **These are important goals that all health care providers should want to attain, but as these relationships change, there is also significant risk to beneficiaries’ access to local care and to the ability of rural hospitals and doctors to provide local services.**”

*Provider Assignment*—“We believe CMS must assure that ACOs recognize the

**uniqueness of health care in rural communities when it comes to primary care providers.** Unlike most urban communities, there are usually not enough providers in rural areas to support multiple ACOs having closed provider networks competing with each other. Many rural communities are located in areas that will have the potential for overlapping ACOs with multiple urban-based networks. **To retain local access, rural communities need local providers to be able to offer their services to multiple ACOs.”**

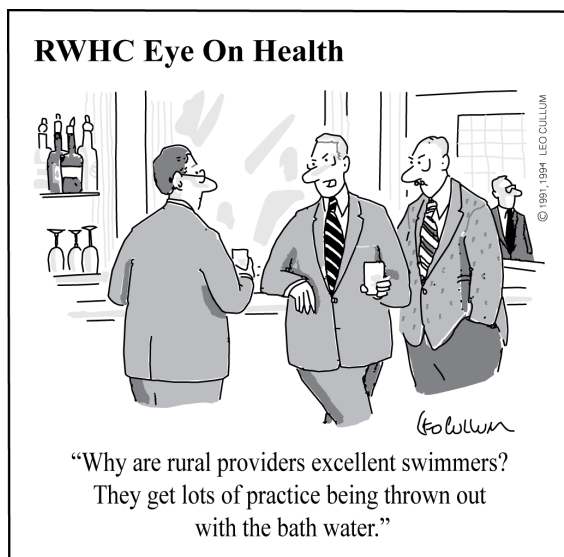
“Many providers cover large geographic areas and coordinate the care of their patients with multiple facilities based on the convenience of patients served. Allowing physicians in rural areas to participate in multiple ACOs provides the needed flexibility for rural environments and ensures meaningful access for Medicare beneficiaries residing in rural Wisconsin.”

**“We recognize that the initial attribution model is retrospective in nature. However, we are concerned that forcing rural primary care physicians to align with a single ACO will have the long term effect of splintering rural regions into various subparts, each dominated by a single ACO.”**

“We believe CMS could develop a two-step attribution model for rural primary care physicians: first, costs are divided amongst primary care physicians; and then second, costs are attributed between two or three ACOs depending on which ACO’s specialists predominated with that primary care physi-

cian’s patients. This would require specialists to declare a principle ACO affiliation as primary care physicians are asked to do.”

“CMS should develop and test a rural model in addition to the proposed urban-centric model. The current lack of a rural ACO model reminds us of when CMS introduced the wage index and every MSA got its own index and the rest of the state was thrown into one pot of leftovers.”



*ACOs Effect on Rural Health Care*—“**It must be recognized that ACOs have the potential to destabilize the existing rural safety net.** Once we are beyond the initial gain-sharing pilots, it is not known whether or not ACOs will be required to honor existing Medicare rural add-on payments for safety net providers such as Critical Access Hospitals (CAH) and Rural Health Clinics (RHC). CMS needs to be very thoughtful (concerned) how the model will evolve in commercial insurance markets and/or future iterations under Medicare.”

“In the future, some regional ACOs could be able to negotiate payment rates with local rural providers that are at levels below the rates the providers currently receive under Medicare. This is a process that presents more risk to rural areas where providers may have little managed care type contracting experience and little or no negotiating power.”

“This would probably be most evident in those areas where ACOs may be able to steer patients to other contracted providers. Under traditional Medicare, many rural providers receive special payment rates to reflect the various financial challenges of providing health care in rural areas. There is a concern that future iterations of the ACO model will not recognize these targeted rural special payments that have been part of stabilizing the rural safety net and provided quality health care to Wisconsin residents.”

**“The enforcement of Community Access Standards is absolutely critical to prevent steerage of Medicare beneficiaries and inordinate leverage by Medicare ACO plans against rural providers.”**

“While the first generation of Medicare ACOs proposes to use a retrospective attribution model, it is reasonable to expect the model to evolve over time to a prospective attribution model, requiring closed provider networks. To that end, it is important that the first generation of ACOs meet strong access standards. CMS and Wisconsin have previously dealt with this issue in the context of managed health care regulation.”

“Wisconsin Statute 609.22 requires health plans (with closed provider networks) to respect ‘...normal practices and standards in the geographic area,’ and Wisconsin Insurance Code 934 (2) (a) requires, with re-

spect to managed care plans, ‘geographical availability shall reflect the usual medical travel times within the community.’ The current CMS language for Medicare Advantage plans is similar.”

“There is much uncertainty in our country and the health care field. While we understand some of the general direction, we just don’t know what exact forms reform will or will not take. So we need to encourage all of us in rural health to look to strengthen the core competencies of doing more, better for less—and that the only way that can happen is through significantly greater care coordination and population health focused prevention, using a full range of corporate integrated and virtual collaboration models.”

“Wisconsin’s health care model has worked well, according to the Dartmouth Atlas; Wisconsin was more than 15 percent below the national average in total Medicare reimbursements per enrollee in 2006. In addition to Wisconsin hospitals being a leader in lowering costs, they have been ranked in the top two for quality by the Agency for Healthcare Research and Quality in each of the last three years.”

“CMS has stated that it only intends for 5-10% of the hospitals in America to participate initially in the program and still faces considerable challenges in the formulation of ACOs. We would argue that rural facilities face a number of challenges with meaningful participation in the program as currently structured. CMS needs to create positive, workable rural solutions that reward better care at a more reasonable cost. ACOs are an important part of health reform in America, but as currently defined by CMS. RWHC believes they are largely impractical for most of rural America.”

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## Education, Jobs & Health: Bound at the Hip

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by Tim Size, RWHC Executive Director

Each spring, the University of Wisconsin publishes a report: *County Health Rankings, Mobilizing Action Toward Community Health*. Part of the news continues to be not good. Rural people in Wisconsin continue to be less healthy and die sooner than their ur-

ban friends and relatives. Part of the news is good. Rural communities are taking action.

The UW report paints a stark contrast. Four of the five least healthy Wisconsin counties are rural. Four of the five healthiest counties are urban.

When I look at the healthiest counties I think of the guy who was born on third base and thought he hit a triple. But this is a story more like the first rule of real estate—it's location, location and location.

The main point of *County Health Rankings* is that the impact of a rural location on health is not fixed. There are rural counties that are among the healthiest and others that are actively working to improve their ranking. We can change what affects our health and make our communities and ourselves healthier.

Rural doctors and hospitals make a difference. But as hard as that work is, it is only part of the story. Social and economic issues like education, employment, income and our own behaviors like smoking, diet and alcohol are also major drivers of our health.

So what do we do? We need to commit to the idea that education, jobs and health are bound at the hip. We need to work for strong rural health and health care. We also must work to create jobs as well as support those working to educate our kids. These are not competing goals. You don't achieve one apart from the others.

What ever you do, the *County Health Rankings* website can help you work with others to mobilize your community. The Robert Wood Johnson Foundation supports a major online resource. (Google "county health rankings.") It is well worth your time to investigate the tools that are available.

Local school districts and Cooperative Educational Service Agencies throughout rural Wisconsin are getting involved. Students are learning the importance of healthier lifestyles. Physical fitness and wellness topics are being brought into more classes. They are no longer confined to the gym and a single class on health "issues."

Programs like the Farm to School are using local producers to improve the nutritional quality of school lunches.

The job of employers is to grow their business. And hopefully also create local jobs. But they can also encourage employee fitness. They can educate all managers about the link between employee health and productivity. The *County Health Rankings* report makes clear that "a county's health affects its economic competitiveness. Achieving lower health care costs, fewer sick days, and increased productivity are all critical to economic growth."

Economic development enterprises are focusing on long-term, sustained results, aimed at building their region's competitive advantage. One such group, Thrive in southern Wisconsin, is also encouraging healthcare and business leaders to work together. It believes healthier workplaces "drive down healthcare costs and increase employee engagement and productivity."

The *County Health Rankings* also helps health care professionals identify the underlying causes of health problems. "We can prevent many of the health problems seen every day in the clinics and hospitals. All of us have a role to play to improve the multiple factors that affect the health of our communities." All of us working in health care are uniquely positioned to partner with others to mobilize our communities to become healthier.

Barbara Theis, Juneau County's health officer, is a role model for many of us. "In 2006, Juneau County was the unhealthiest county in the state, but we turned it around, we challenged ourselves. We're moving

### RWHC Eye On Health



"If no one lived around here, we could really save on the cost of health care and public education."



forward, and we have committed stakeholders that are working together to make our county one of the healthiest. Rural Wisconsin needs more Juneau Counties.”

#### RWHC SOCIAL NETWORKING RESOURCES

Web: [www.rwhc.com](http://www.rwhc.com)  : [RWHC](#)  : [RWHC](#)  
Blog: Rural Health Advocate: [www.ruraladvocate.org/](http://www.ruraladvocate.org/)  
Blog: Rural Health IT: [www.worh.org/hit/](http://www.worh.org/hit/)

with Clarity Group, Inc. on the Benchmark for Excellence in Patient Safety™ Program. We have been using Clarity’s Healthcare SafetyZone® Portal since January of

2010 and now have 10 hospitals in our network that have gone paperless and have been able to benchmark with one another. It is very exciting to have this same opportunity with other small and rural hospitals across the country.”

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## First National Rural Patient Safety Initiative

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From press release “Clarity Group Launches the First National Benchmarking Program in Patient Safety for Critical Access, Small and Rural Hospitals,” 6/11:

“Clarity Group, Inc. (Clarity) a leading healthcare resource specializing in integrated risk/quality/safety systems and captive insurance company development and management, announced today a complimentary webinar to launch a new program that focuses on patient safety and benchmarking in critical access, small and rural hospitals. Building on its statewide programs with the University of North Dakota, Center for Rural Health Quality Network and the Rural Wisconsin Health Cooperative (RWHC), Clarity is pleased to offer this opportunity to critical access, small and rural healthcare providers.”

“ ‘Clarity is proud to be working with many critical access, small and rural facilities nationally in the areas of quality and patient safety event collection and management, and together we are introducing the National Benchmark for Excellence in Patient Safety™ Program. We believe this program is the first of its kind for CAHs and small healthcare facilities and we are pleased to advance patient safety with these highly dedicated providers,’ stated Anna Marie Hajek, President/CEO of Clarity Group, Inc.”

“Using the Healthcare SafetyZone® Portal, a web-based event management tool, CAHs and small hospital facilities are able to collect data and complete timely investigations to resolve events from all across their facilities.”

“According to Beth Dibbert, RWHC Quality Consultant, ‘RWHC is very excited to be working

“The Clarity product offers strong value for money paid, and Flex Grant monies provided through the Wisconsin Office of Rural Health made CAH participation even more affordable. The Benchmark for Excellence in Patient Safety™ Program is a great way to share our experiences and continue our pursuit of improved patient safety in small and rural settings.”

“The North Dakota CAH Quality Network first teamed with Clarity Group, Inc. in September of 2008. Since that time, the network of 13 critical access hospitals has submitted more than 14,000 events in the Healthcare SafetyZone® Portal.”

“According to added Jody Ward, North Dakota CAH Quality Network Coordinator, ‘we also have benefited from Flex Grant money through the ND Center for Rural Health supporting in part our critical access facilities purchasing the Portal. Among the benefits we have seen, we have been able to utilize this technology to eliminate paper from our organizations, increase our overall reporting, and foster shared learning and communication among our facilities. The Benchmark for Excellence in Patient Safety™ Program is a great way to aid in our continued focus on improving patient safety in small and rural hospitals. We are very excited to have the opportunity to network with other small and rural hospitals in other states and have the chance to benchmark and learn from one another.’ For more info, visit [www.claritygrp.com](http://www.claritygrp.com)

#### 19<sup>th</sup> Annual RWHC Monato Essay Prize Winners Announced

The First Prize of \$2,000 was awarded to Jeyanthi Bhaheetharan for “Dental Health Care Access in Rural Communities.” A first ever Honorable Mention of \$1,000 was awarded to Caitlin Rublee for “Addressing the Physician Shortage Epidemic One Shot at a Time.”

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## Helping Patients Focus on Care Not Cost

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The Wisconsin Hospital Association (WHA) annually surveys its 131 member hospitals and asks them to describe and quantify the programs, services and activities that they provide at or below cost, solely because those programs fulfill a health need in the community. In 2009 hospitals provided nearly \$1.18 billion in community benefits and more than 735 patients per day received their hospital care free of charge. One such story is “Allowing patients to focus on care, not cost” from Memorial Medical Center, Neillsville:

“Jewel had not been to a physician in seven years, but her health problems had grown to a level where she couldn’t eat, sleep, work, or even sit still at times. ‘I wanted to punch walls out, I was in so much pain. I needed an appointment, like yesterday,’ she explained. During her appointment with Dr. Amy Coulthard, Jewel wanted to be upfront about her lack of insurance and limited income. She was scared about what might be wrong with her, and how much it would all cost. Dr. Coulthard assured her that she would still receive a

complete physical, lab work, mammogram, and then she helped guide Jewel to reduced-cost medications. Finally, Dr. Coulthard connected Jewel with Wendy Proffitt, the patient financial services supervisor at Memorial Medical Center.”

“ ‘I worked with Jewel on our Community Care application, and also provided her with information to BadgerCare and the Wisconsin Well Woman’s program,’ remarked Proffitt. Jewel did get her screening mammogram, and was subsequently referred for ultrasound and diagnostic mammogram. Ultimately, she needed to have a biopsy. ‘I was relieved when I found out that I didn’t have cancer, and I thought, if I just keep working with Wendy, I’ll find a way to stay straight with the hospital,’ stated Jewel.”

“Jewel’s Community Care application was approved, and nearly \$7,000 was deducted from her total medical bill. Jewel is currently feeling better and going to online school for a degree in Business Administration. ‘When I get my degree, I’m going to be able to pay more bills off. I’m thankful for good health, good care, and good people in Neillsville.’ ”

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