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Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2010

Are We Governable?

From "Senate's Gridlock Fuels Frustration" by Naftali Bendavid in *The Wall Street Journal*, 2/10:

"The Senate's plodding pace has always distressed those in Washington eager to get things done quickly. Now, with Democrats and Republicans stalemated on everything from major legislation to agency appointments, some are asking whether the institution is broken."

"The Obama administration's frustrations hit a peak last week when one Republican senator, Richard Shelby of Alabama, placed a 'hold' on more than 70 pending nominations because he objected to proposed Pentagon budget cuts that threatened jobs in his state. Mr. Shelby relented, saying he is satisfied he got the administration's attention. But Mr. Obama took a swipe at Mr. Shelby during an unscheduled meeting with reporters Tuesday."

" 'I respect the Senate's role to advise and consent, but for months qualified, noncontroversial nominees for critical positions in government–often positions related to our national security–have been held up despite having overwhelming support,' Mr. Obama said."

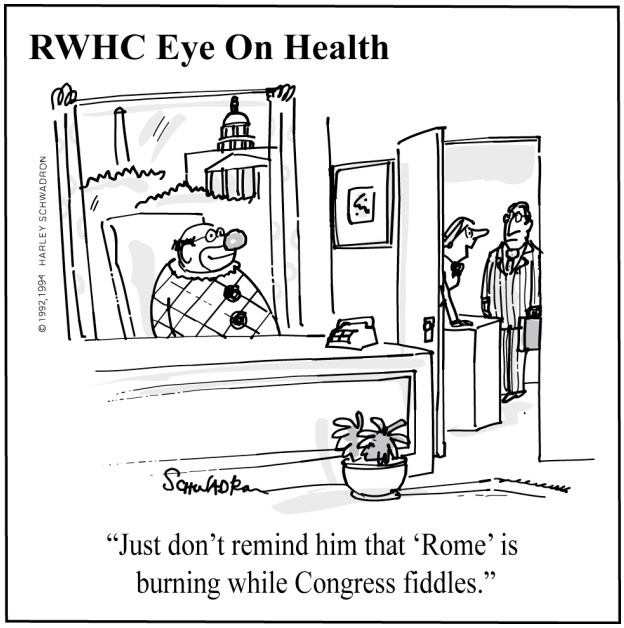
"The president said he may begin making appointments during the coming congressional recess, which would allow those nominees to serve temporarily without a Senate vote."

"The dispute over nominees is only the latest flare-up prompting arguments over whether the Senate's complex rules give too much power to the minority party and to individual senators."

"Senators took months to debate a health-care overhaul as leaders scrambled to secure the 60 votes needed to overcome an expected filibuster. Along the way, Democratic leaders offered a series of enticements to wavering senators, which turned off voters. Republicans used tactics such as a forced reading of the entire bill to slow its progress."

"Democrats are especially frustrated that even with two major election wins behind them and a majority of 59–a historically unusual dominance by one party–they have been stymied by the 60-vote threshold and unified Republican opposition. Another obstacle is the requirement for "unanimous consent" before certain actions can be taken, meaning any senator can object to the proceedings."

" 'The Senate is almost dysfunctional now,' said Sen. Tom Harkin (D., Iowa). 'It's 100 times worse. It used to be we would have one or two filibusters per Congress, and they were only used for big important issues.' He has proposed a rule change making it harder to filibuster."



"Just don't remind him that 'Rome' is burning while Congress fiddles."

"Senate Minority Leader Mitch McConnell (R., Ky.) has said Republicans aren't obstructing but have been shut out by Democrats."

"Critics ask whether the Senate is capable of tackling big problems anymore. Apart from health care, a Democratic plan to rewrite energy policy is also stuck in the Senate; in the face of the biggest financial crisis in decades, attempts to devise new bank regulations are bogging down; and amid high unemployment, senators are struggling to craft a bipartisan jobs bill."

"Activists on the right and left say the problems go beyond Senate rules, which have been in place for decades. Liberals say Senate Majority Leader Harry Reid (D., Nev.) should exercise his clout, threatening Democrats who stray and using a process called 'reconciliation' that needs just 51 votes for certain bills. Reid spokesman Jim Manley suggested outsiders often don't fully recognize procedural constraints."

"This is America; That's How It Works"

The following commentary was specially written for "Eye on Health" by Thomas E. Hoyer, Jr., Federal Center for Medicare and Medicaid Services, retired and a member of the federal National Advisory Committee on Rural Health and Human Services.

I've long since stopped reading the details of negotiations on the health care bill; even stopped reading the outraged articles about who got paid off with what inclusion or exclusion. It's all so tiresome and so familiar.

In my long Medicare life, I worked on our Christian Science Sanatorium benefit, a little known benefit enjoyed for decades by twenty odd Christian Science Sanatoria because some senators who were Christian Scientists had votes LBJ needed for Medicare. I spent years working on hospital cost limits and then prospective payment, not to mention medical review, to deal with the going-in offer: cost payments.

I even worked on the RBRVS that finally replaced Medicare's initial offer to pay physicians whatever the "customary charge" was where they practices. I spent some time working with Medicare's subsidy to medical education, the labor-union based pre-payment plans, and other concessions on the bill. I worked for more than five years to get nursing home standards in place, and an enforcement system that would really enforce them, to roll back our going in position on 'substantial compliance' and our tolerance for eternal plans of correction.

More than forty years later, Medicare is lumbering towards maturity, still weighed down by ornaments bestowed by a Congress designed to operate on the competition among interests.

Here's what I know. Getting a reform bill, like getting to Medicare, will be a process of making concessions in the interests of a majority. Implementing it and operating the program will be an exercise in inching forward, bit by bit, driven in no small part by the fiscal threats that the implementing concessions embedded in the structure. This is America; that's how it works. So, I say, bring it on... Let's get started.

EHR Program: Stretch Without Breaking

From a blog by Louis Wenzlow, RWHC Director of Health Information Technology and the Chief Information Officer of the RWHC Information Technology Network, at "Rural Health IT" blog at: **www.worh.org/hit/**

RWHC Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative, begun in 1979, 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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Email **office@rwhc.com** with *subscribe* on the Subject line for a free e-subscription.

"Let's Get Meaningful–One thing we can all agree on: for Medicare's Electronic Health Record (EHR) incentive program to be meaningful, it needs to be designed to support our national goals of reducing healthcare costs and increasing healthcare quality. We're moving to electronic health records not for the technology's sake, but because we believe the technology is a means to actually help people and make things better."

"The main area where people disagree is whether or not the meaningful use bar has been set too high to facilitate the accomplishment of these common goals. Those who argue for a high bar believe that lower standards will lead to watered down benefits. Those who argue for a lower bar believe that unachievable standards will lead to dramatically fewer providers making EHR adoption (and accompanying quality and efficiency) gains.

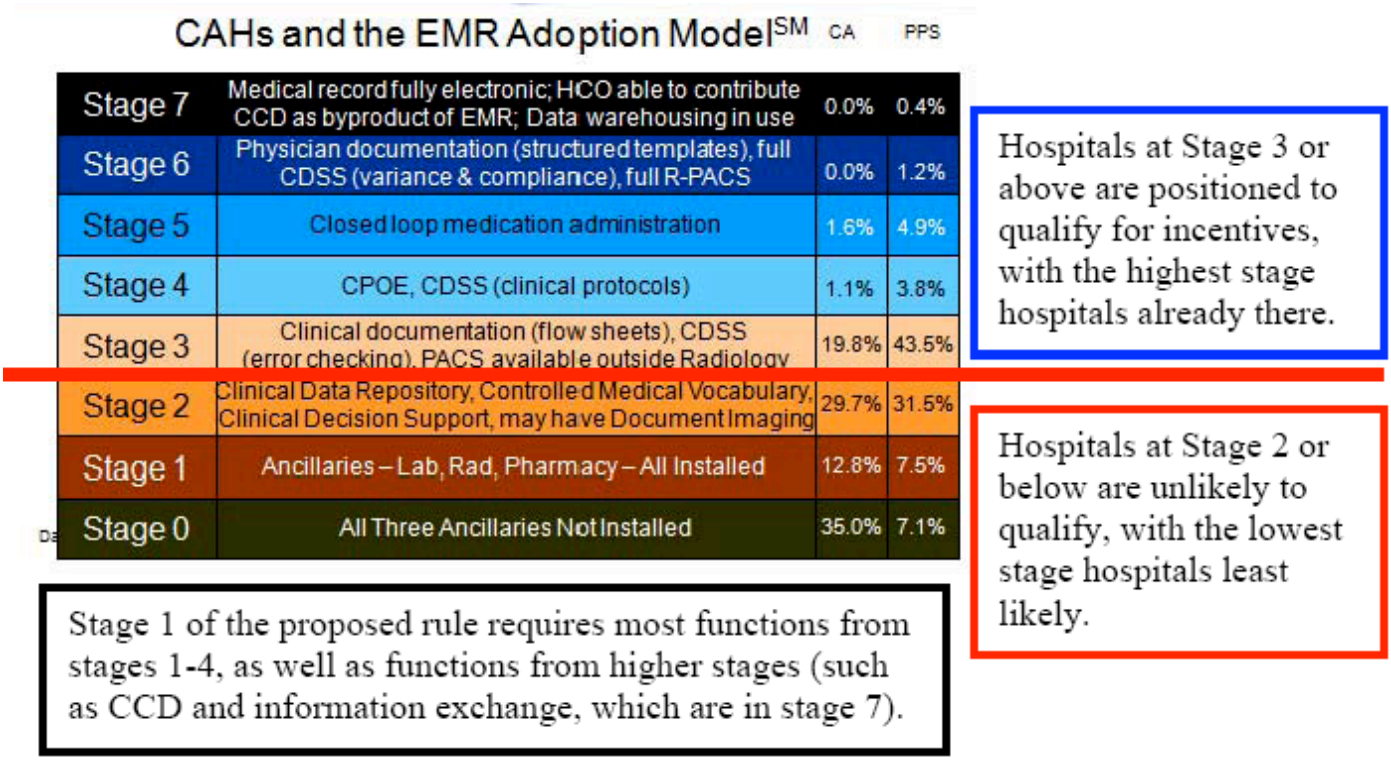
"Mixed into all this are accusations from high-bar proponents that people who disagree with them are lazy whiners who should be focusing on meeting the standards rather than arguing against them, as well as suspicions from lower-bar proponents that advanced-EHR hospitals, systems, and provider groups have found a way to skim billions from the tax-payer trough for work that they have already done."

"Let's leave behind the name-calling and get meaningful!"

"Stretch Don't Break–According to The Office of the National Coordinator for Health Information Technology (ONC), the principle for determining the meaningful use bar is to find the appropriate balance between feasibility and urgency. National Coordinator Dr. David Blumenthal has recently said that he intends to 'stretch but not break' the healthcare community in setting the threshold for meaningful use."

"I agree with this principle of 'stretch don't break,' but it's unclear to me how and even whether it is being applied. What seems to be getting lost in the discussion is that it is logically impossible to 'stretch not break' hospitals and physicians that are at very different stages along a continuum of EHR adoption by using a single rigid meaningful use standard. If you stretch providers at advanced stages of EHR adoption, those at early stages will break. If you don't break providers at early stages of adoption, those at advanced stages won't stretch."

"The chart on this page, illustrates the issue. The colorful 7 stage grid includes Healthcare Information and Management Systems Society (HIMSS)-provided percentages of critical access hospital

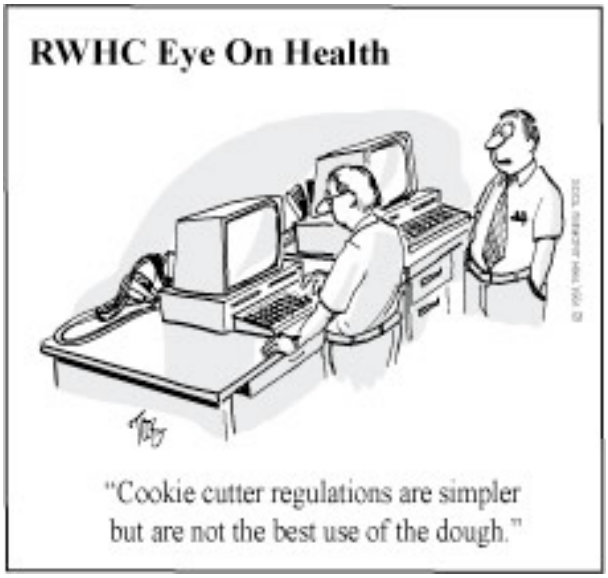


(CAHs) compared to prospective payment system (PPS) hospital electronic medical record (EMR) adoption statistics. I have added three text boxes to indicate (1) the CMS Stage 1 meaningful use threshold (black); (2) my assessment of the HIMSS stages that are least likely to meet these thresholds (red); and (3) my assessment of the HIMSS stages most likely to meet these thresholds (blue)."

"In this comparison, 70% of CAHs are at stages that I believe are less likely to achieve meaningful use, compared to 46% of PPS hospitals. 48% of CAHs are at the two lowest stages of adoption, compared to 15% of PPS hospitals."

"We could (and should) do this same analysis with rural, small, disproportionate share, independent, and other categories of hospitals. The point of this is that when we talk about 'stretch don't break,' we need to clearly identify where providers are starting from, what timing requirements we are assuming are reasonably achievable, and what types of providers we are specifically referring to."

"Americans who live in communities where providers are likely to have lower levels of EHR adoption have a right know that ONC and CMS have decided to 'break' their local rural providers in order to 'stretch' the urban ones a hundred miles away."



"How to Stretch All Providers–If we are truly committed to stretching without breaking, how do we do this for all of our providers, whether urban or rural, small or large, independent or system-owned, PPS or CAH?"

"One way is to create more than one meaningful use bar, so that providers at different stages can all be incented to make meaningful EHR adoption strides with consideration paid to their starting points."

Another way is to allow for flexibility. Instead of creating a one-size-fits-all, all-or-nothing standard, why not allow providers to select the 90% of the requirements that are most suitable for their environments? If we force providers to move faster than what is a reasonable stretch we will in all likelihood see lower not higher quality. (See my blog "CMS Proposed Rule Threatens Care Quality in Rural Communities" at **www.worh.org/hit/**)

"A third way is to simply exempt certain types of providers from a portion of the meaningful use requirements, at least initially. If we know that it is unreasonable to think that 70% of CAHs and rural hospitals can implement Computerized Provider Order Entry (CPOE) in time to receive incentives that could go toward other important EHR adoption work (such as Pharmacy systems with contraindication checking capabilities and inpatient nurse documentation systems), then why are we requiring CPOE for these types of hospitals?"

"There are those who have come to the false conclusion that there is a secret sauce, an EHR implementation recipe that, if only all providers follow the instructions in the exact same way, will somehow fix the problems of our healthcare delivery system. My experience, which I think is borne out by most of the existing research, is that no such single recipe exists. Rather, EHR implementation success depends on an organization's ability to ascertain the distinctive combination of interventions and strategies that will work within the organization's specific environment."

"According to the federal Agency for Healthcare Research and Quality's statement on *Costs and Benefits of Health Information Technology*, 'Health information technology implementation consists of a complex organizational change undertaken to promote quality and efficiency. Studies of organizational change are fundamentally different from studies of medical therapies. Organizational interventions interact with a wide range of organizational system components. To be successful, they must address these

components in a locally effective way. Thus, in a sense, these interventions are by nature not widely generalizable…' "

"How are we accounting for this dynamic complexity by imposing the same rigid all-or-nothing meaningful use standard on every type of provider?"

Rolling Rural Web Access

From "Wi-Fi Turns Rowdy Bus Into Rolling Study Hall" by Sam Dillon in *The New York Times*, 2/12/10:

"Students endure hundreds of hours on buses each year getting to and from school in this desert exurb of Tucson, and stir-crazy teenagers break the monotony by teasing, texting, flirting, shouting, climbing (over seats) and sometimes punching (seats or seatmates)."

"But on this chilly morning, as bus No. 92 rolls down a mountain highway just before dawn, high school students are quiet, typing on laptops."

"Morning routines have been like this since the fall, when school officials mounted a mobile Internet router to bus No. 92's sheet-metal frame, enabling students to surf the Web. The students call it the Internet Bus, and what began as a high-tech experiment has had an old-fashioned–and unexpected–result. Wi-Fi access has transformed what was often a boisterous bus ride into a rolling study hall, and behavioral problems have virtually disappeared."

"On this morning, John O'Connell, a junior at Empire High School here, is pecking feverishly at his MacBook, touching up an essay on World War I for his American history class. Across the aisle, 16-year-old Jennifer Renner e-mails her friend Patrick to meet her at the bus park in half an hour. Kyle Letarte, a sophomore, peers at his screen, awaiting acknowledgment from a teacher that he has just turned in his biology homework, electronically."

"Internet buses may soon be hauling children to school in many other districts, particularly those with long bus routes.

"Karen Cator, director of education technology at the federal Department of Education, said the buses were part of a wider effort to use technology to extend learning beyond classroom walls and the six-hour school day. The Vail District, with 18 schools and 10,000 students, is sprawled across 425 square miles of subdivision, mesquite and mountain ridges southeast of Tucson."

"District officials got the idea for wiring the bus during occasional drives on school business to Phoenix, two hours each way, when they realized that if they doubled up, one person could drive and the other could work using a laptop and a wireless card. They wondered if Internet access on a school bus would increase students' academic productivity, too."

"But the idea for the Internet Bus really took shape in the fall, when Mr. Federoff was at home, baby on his lap, and saw an advertisement in an electronics catalog offering a 'Wi-Fi hotspot in your car.' "

" 'I thought, what if you could put that in a bus?' he said. The router cost $200, and came with a $60 a month Internet service contract. An early test came in December, when bus #92 carried the boys' varsity soccer team to a tournament nearly four hours away. The ride began at 4 a.m., so many players and coaches slept. But between games, with the bus in a parking lot adjacent to the soccer field, players and coaches sat with laptops, fielding e-mail messages and doing homework–basically turning the bus into a Wi-Fi cafe, said Cody Bingham, the bus driver for the trip."

"Mariah Nunes, a sophomore who is a team manager, said she researched an essay on bicycle safety. I used my laptop for pretty much the whole ride,' Mariah said. 'It was quieter than it normally would have been. Everybody was pumped about the games, and there were some rowdy boys. But the coach said, 'Let's all be quiet and do some homework.' And it wasn't too different from study hall."

"Since then, district officials have been delighted to see the amount of homework getting done, morning and evening, as Mr. Johnson picks up and drops off students along the highway that climbs from Vail through the Santa Rita mountains to Sonoita. The drive takes about 70 minutes each way."

"Déjà Vu All Over Again"

From the "Final Report of the North Carolina Hospital and Medical Care Commission to the Governor and 1945 General Assembly" submitted by Thomas C. Ricketts, Deputy Director, Cecil G. Sheps Center for Health Services Research and Professor, Health Policy and Management and Social Medicine at the University of North Carolina at Chapel Hill:

The Need for Rural Physicians

The number of general physicians practicing in rural areas, or among rural people, becomes distressingly smaller every year. In 1914 there were 1,125 physicians living in rural areas of the state. By 1940 the number of rural physicians had decreased to 719. Seventy-three per cent of our state's population, but only 31% of our physicians lived in rural areas in 1940. (Rural includes all towns under 2,500 in population).

As older rural physicians retire or die, few young physicians move in to take their places. In 1914 only 14.6% of our rural physicians were over 55 years of age, as compared with 37.5% in 1940. Only 29-6% of the urban physicians were over 55 in 1940.

The tendency of young physicians to specialize accentuates the rural problem. In 1914, only 3.3% of the state's physicians were full-time specialists, as compared with 22.7% in 1940.

RWHC: Your Partner Your Source

This overview of the Rural Wisconsin Health Cooperative is provided for readers not familiar with RWHC; more information is available at our newly redesigned web site: ***www.rwhc.com***

The Mission of Rural Wisconsin Health Cooperative's (RWHC) is that rural Wisconsin communities will be the healthiest in America. We believe that rural hospitals can help make healthy lifestyles a trademark of their communities–improving health status, reducing avoidable health care utilization and helping to attract and retain jobs. Rural has an extra challenge. Rural counties are typically the least healthy in a state, particularly compared to suburban communities and small cities. We believe that hospitals, clinics, public health agencies and employers working together in rural communities can help employees, their families and their communities become healthier.

The RWHC Vision is that we are a strong and innovative cooperative of diversified rural hospitals; it is the "rural advocate of choice" for its members as well as developing and managing a variety of products and services. We believe that our ability to meet our vision depends on acting in accordance with these Core Values: Trust, Collaboration, Creativity, Excellence, Joy, Openness, Personal Development, Productivity and Responsibility.

Incorporated in 1979 as the Rural Wisconsin Hospital Cooperative, RWHC has received national recognition as one of the country's earliest and most successful models for networking among rural hospitals. The National Rural Health Association, the National Cooperative of Health Networks and the Wisconsin Hospital Association have given RWHC their top award available to an organization or program. The work continues as the renamed Rural Wisconsin *Health* Cooperative responds to rural hospitals' increasingly diverse role in their communities.

RWHC serves as a catalyst for statewide collaboration and as a creative force on behalf of all rural health constituencies. Owned and operated by 35 non-profit rural acute, general medical-surgical hospitals, RWHC's charge is twofold: shared service development for cooperative hospitals and external customers as well as advocacy for rural health at the State and Federal levels.

The tenants of shared service and advocacy have benefited one another over the years. Advocacy is more credible as RWHC is seen not just as a "mouth piece" but as a mission driven group–not just talking but adding "real" value. Shared services and advocacy require pretty much the same infrastructure so a cooperative of rural hospitals organized for shared

services forms a natural critical mass for advocacy and vice versa.

RWHC Social Networking:

The Rural Health Advocate: www.ruraladvocate.org/

Rural Health IT: www.worh.org/hit/

A central service available to members is RWHC roundtables. RWHC directly addresses the geographic isolation associated with rural health by sponsoring over three dozen professional roundtables, representing a wide range of clinical and non-clinical disciplines. Most of these roundtables meet 4-6 times per year, typically for 2-4 hours per meeting; participation is in person, by phone and increasingly via videoconference.

RWHC's shared services, like our roundtables, have been a major source of advocacy initiatives. Examples include: (a) the Quality Roundtable's work related to rural relevant public reporting, (b) the RWHC Network's promotion of rural access standards and (c) the CFO Roundtable leading to action on multiple Medicare and Medicaid reforms.

Since its inception, RWHC has maintained a philosophy of "together, we are better", working collaboratively to represent smaller rural hospitals as an important stakeholder at the policy maker's table. Initiatives as diverse as facilitating Critical Access Hospital conversions and developing shared rural HIT systems have energized RWHC's expertise in crafting rural health policy. That expertise continues to help shape the landscape of rural health services in America.

RWHC's internal monthly newsletter, *Eye On Health*, began to be shared externally in 1995. Since then it has attracted a national readership among key rural health leaders. It is known for its eclectic mix of original articles and abstracts from a diverse array of news items, editorials and published research. Some readers appreciate *Eye On Health* for having the country's longest lasting rural health cartoon series.

RWHC Eye On Health

"I like it, but 'Thou Shall Not Fail To Cooperate When Resources Are Scarce' makes eleven."

Shared services have grown through collaborative efforts, and continue to provide sound quality programs to our rural partners in Wisconsin and around the country. At the heart of RWHC service line development is the desire to be an *affordable and effective option* for rural health organizations. Our focus includes *quality (core measures, noncore measures and patient satisfaction), finance, HIT, credentialing, and reporting capabilities to regulatory agencies*. RWHC's business model gives us the opportunity to deliver services that are innovative and reliable, yet affordable for the smaller hospital. With more than 30 years of experience, RWHC continues to be recognized as a leader providing shared services to smaller hospitals.

Continued growth has lead RWHC to establish three additional standalone business entities. Early in 1997, RWHC incorporated RWHC Network as a mechanism for its rural members to talk with each other and jointly negotiate with health insurance companies without violating antitrust laws. This critical step forward was made possible by notification from the Federal Department of Justice that they had accepted RWHC's request for a Business Advisory Letter. This decision was based on the demonstration that RWHC rural hospitals don't compete with each other but with the problem of patients leaving the local community for care in large, regional medical centers. Consequently, RWHC hospitals can now work together within the parameters of the Business Advisory Letter to negotiate with health plans and others with less concern of violating strict federal antitrust laws.

Working together through the RWHC Network led some members to create RWHC, LLC a Physician Hospital Organization (PHO), formed to negotiate and execute Medicare Advantage contracts on behalf of its members. Membership in the PHO does not require membership in RWHC, and is thus open to physicians, non-RWHC member hospitals, and other providers. The PHO offers a service to members so that they do not need to spend time and other resources on these contracts, and it offers a benefit to Medicare Ad-

vantage plans in providing a single contracting source for multiple providers.

In 2007, RWHC and member hospitals founded the RWHC Information Technology Network, a 501(c) 3 organization dedicated to providing member hospitals with shared HIS/EHR services. Four RWHC facilities signed on as founding members. Helping to support the initiative, three grants were awarded to RWHC: (1) HRSA's CAHHIT Network grant for $1.6 million; (2) FCC's Rural Healthcare Pilot Program for up to $1.5 million; and (3) a federal appropriation through Senator Herb Kohl's office for $181,000.

Rural Hospitals as Part of the Safety Net

The Wisconsin Hospital Associations' Community Benefits Report shows that Wisconsin hospitals provide over $1.6 billion in community benefits; twice that if you include Medicare shortfalls and bad debt. This month's story is from RWHC Member Mound View Memorial Hospital & Clinics in Friendship:

"A growing, painful lump on Mae's neck had her concerned. She was 62 years old, had no job, no health insurance, was denied coverage by Medicaid, and was too young to quality for Medicare. She decided to ask about her lump while at her mentally challenged son's check up with Dr. Jason Bellak at Moundview Clinic. She explained her circumstances and asked Dr. Bellak if there were any physicians who might examine her to let her know what the lump was. He took a look and told her to immediately see Cindi Hildebrand, Moundview Memorial Hospital's Financial Advisor."

"Moundview, like many Wisconsin hospitals, has policies in place to ensure that all patients are seen regardless of whether they qualify for charity care or not. Following tests and surgery at Moundview to remove the lump, Mae was diagnosed with Stage III Lymphoma. She completed her chemotherapy treatments at another hospital with Dr. Bellak keeping in close contact with her oncologist. Today Mae is in remission. She still sees her oncologist every three months and Dr. Bellak for check ups. 'I am so grateful,' said Mae. 'I probably would have had only months to live if I hadn't had treatment.' "

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