Rural Wisconsin
Health Cooperative

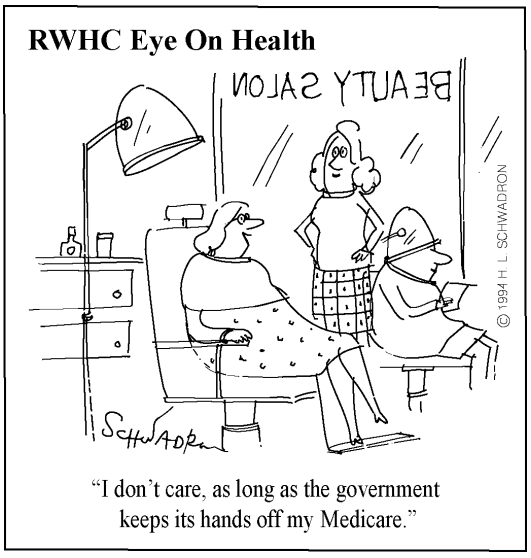
Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective – January, 2009

An Opportunity for American Healthcare

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative, Sauk City, Wisconsin

Even with or maybe because of our severe economic downturn, "healthcare reform" is back on the front burner. The fall election results were a lot about seeking economic stability and security. Healthcare reform is part of that search. Federal and State government deficits make reform harder but not impossible.



I have never liked the words "healthcare reform" as to me it implies good people fixing bad people. "Bad" kids used to be sent to *reform* school. Or we need to *reform* how we finance elections to limit bad things from happening. We won't improve American healthcare by reforming millions of dedicated clinicians and healthcare workers. We won't improve healthcare by reforming away care that most of us like. Most of us can afford our out of pocket healthcare costs, if we keep our jobs.

It is another story when you try to assure that <u>all</u> Americans, all of our neighbors, receive the care they need without going bankrupt. Whether or not they have a job. We could easily be them. It is another story that we are long overdue in finding ways to encourage cost savings. We over utilize services and are under concerned about how our own behaviors affect our health. This failure makes our businesses less competitive; it causes jobs to be lost and is bankrupting private and public health plans alike. We need to keep what is good and make the other bits much better–"not throw the baby out with the bathwater." But we cannot afford to lose this opportunity to improve how we organize, use and pay for healthcare.

After the election, the nation's largest health insurance companies surprised many of us. They announced a major shift in what healthcare reform they could live with. Insurers may be saying that they will no longer compete by avoiding sick people. So what if it is a concession to political reality? It is still welcome news. But they add a condition. There must be an enforceable mandate that everyone has health insurance. This is reasonable. In the absence of such a mandate, many people may wait until they become sick before they buy insurance. This would be like buying homeowners insurance after the house is on fire.

Celebration may be premature. David Hamilton is a 14-year veteran of the *Wall Street Journal* who has a blog on www.bnet.com. He describes three sticking points not mentioned by the health insurers:

Enforcement of the mandate–"No one yet has come up with a combination of carrots and sticks that is not either wholly inadequate or politically toxic."

Premium costs–"The insurers did not agree to 'community rating,' where all individuals in a defined insurance pool pay the same premium. (Group insurance offered by employers typically works this way.) Community rating means that healthy people subsi-

dize the costs of the sick. For example, without it, insurers charge more to people who are sick or more likely to become sick."

Government-run insurance–"A government-run health plan is part of the proposal offered by Present-elect Obama and Sen. Max Baucus, a kind of 'mini-Medicare.' Individuals could choose the government plan instead of private health insurance. There is a fear in a weak economy that this option will drive many away from employer-sponsored health insurance. This may be a 'deal breaker' for some."

America has come a long way from the famous "Harry & Louise" commercials in the early 1990s. They were intended to derail any reform by raising fears of "socialized medicine." The message was successful and helped to sink our country's last run at major health reform. Medicare is a very popular program with the elderly. That it is a government program doesn't seem to bother Medicare beneficiaries although that may be mostly due to the relatively low out of pocket costs they pay.

There appears to be agreement that the political and economic pain of doing nothing now outweighs the pain of doing something. How much or how little private health insurance remains is an open question. "Reform" may be incremental like the growth of BadgerCare in Wisconsin. Or it may be a major change as we saw with the birth of Medicare. One point of agreement that may be reached early given the need for tax revenue, is to reduce the amount of income tax avoided by higher income earners for their health insurance benefit.

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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Real reform must address universal access to healthcare and the cost of healthcare. But it must also focus on what each of us can do to keep ourselves healthy. We must become less dependent on medical care that is often by its nature, expensive. To do less does not solve a fundamental driver of our country's healthcare costs.

Healthcare represents 16% of America's economy; whatever direction our country takes we all will be significantly affected. Hold on tight and get ready for the ride.

The Experts Finally Find a Common Voice?

From a press release, "National Priorities Partnership Sets Action Agenda to Improve Healthcare and Cut Waste During Time of Severe Economic Strain, a National Movement to Spark Transformation in Healthcare in 2009 and Beyond," 11/17/08:

"The National Priorities Partnership–a diverse group of national organizations representing those who receive, pay for, deliver, and evaluate healthcare–released an action agenda to transform healthcare during a time of severe economic strain by-better investing resources to fundamentally improve patient care and outcomes."

" 'There is far too much waste and inappropriate care along with growing numbers of uninsured and persistent disparities in care,' said Janet Corrigan, president and CEO of the nonprofit-National Quality Forum, which convened the National Priorities Partnership. 'These Priorities and Goals are all about the patient. We must make care safer, more effective and affordable for all.' "

"With each member of the National Priorities Partnership wielding influence over major portions of healthcare delivery, the coalition has the power to set in motion a national movement to deliver transformative improvements to America's health and healthcare system. 'The key to our success will be focusing on the right places in our vast and fragmented system where we can achieve the biggest dividends for patients and their families. It is reform

from the inside out–where it has the best chance to succeed,' declared co-chair and Institute for Healthcare Improvement CEO Don-Berwick."

"The Partnership's improvement agenda is well underway, identifying six 'National Priorities' that target reform in ways that will eliminate waste, harm, and disparities to create and expand world-class, patient-centered, affordable healthcare. The 'National Priorities' are:

- Patient and Family Engagement, to provide patient-centered, effective care;
- Population Health, to bring greater focus on wellness and prevention starting in our communities;
- Safety, to improve reliability and eliminate errors wherever and whenever possible;
- Care Coordination, to provide patient-centered, high-value care;
- Palliative and End-of-Life Care, to guarantee appropriate and compassionate care for patients with advanced illnesses; and
- Overuse, to remove waste, encourage appropriate use, and achieve effective, affordable care."

"The nation's economic crisis makes addressing healthcare even more urgent. With healthcare spending on track to reach 50 percent of America's GDP by 2050 and states in severe budgetary straits, cutting waste to achieve savings and better care is an imperative. 'There is broad-consensus among Americans that healthcare needs real change. We must capitalize on this opportunity to improve safety and effectiveness and eliminate waste,' said Partnership co-chair and National Committee for Quality Assurance president Margaret O'Kane. 'The Partnership represents unprecedented consensus–we have brought the right players together at the right time to effect positive, meaningful change.' "

"Moving into 2009 and a new session of Congress, the National Priorities Partnership will enlist other powerful organizations to help fix healthcare, arguably the nation's biggest ongoing crisis. The group will spend the next year marshalling specific, measurable actions to deliver better, more-affordable care."

The complete 72 page report along with more information about the National Priorities Partnership is at: **www.nationalprioritiespartnership.org**

WHEFA's Larry Nines Honored for 25 Years of Steady Service

The Wisconsin Health & Educational Facilities Authority (WHEFA) rightly honored Larry Nines on the occasion of his 25th anniversary as WHEFA's widely known and respected executive director. His high standards and ongoing commitment has had an incredible impact on health and education sectors throughout the entire state of Wisconsin.

In Spite of Challenges, Rural Holds Its Own

From "Hospital Remoteness and Thirty-Day Mortality from Three Serious Conditions, Many hospitals in Rural Areas Perform Well in Treating Acute Myocardial Infarction, Heart failure, and Pneumonia" by Joseph S. Ross, Sharon-Lise T. Normand, Yun Wang, Brahmajee K. Nallamothu, Judith H. Lichtman, and Harlan M. Krumholz, *Health Affairs*, November/December 2008:

"Rural U.S. communities face major challenges in ensuring the availability of high-quality health care. We examined whether hospital-specific, all-cause, thirty-day risk-standardized mortality rates (RSMRs) following acute myocardial infarction, heart failure, and pneumonia varied by hospitals' geographic remoteness. We analyzed 2001–2003 Medicare administrative data, comparing RSMRs among hospitals located in urban, large rural, small rural, or remote small rural regions. We found only small mortality differences across remoteness regions for hospitalizations for the three conditions. We examine the implications of these findings for the millions of Americans who rely upon rural hospitals for their care."

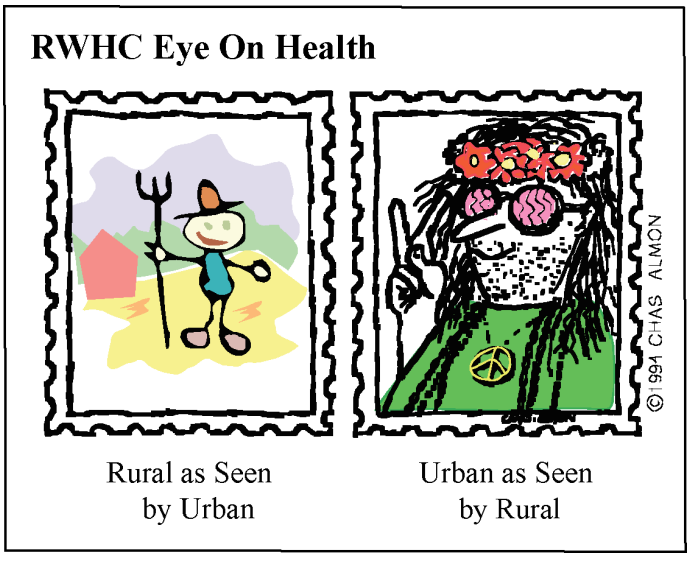
"America's rural communities face considerable challenges in ensuring the availability of high-quality health care. Many hospitals have closed, and others face financial peril, leaving some communities without access to advanced care and emergency services."

"**Moreover, geographic access to health care practitioners in rural communities has increased only**

marginally, leaving some people without access to basic care and more without access to specialty care. Compounding these challenges, rural populations are more likely to exhibit poorer health behavior, such as smoking and sedentary lifestyles, and to be limited in daily activities as a result of chronic conditions when compared with urban populations. However, it is not known if rural populations have worse outcomes associated with acute medical conditions—an area of research prioritized by the Institute of Medicine (IOM)."

"Recent national efforts have sought to characterize the performance of hospitals in caring for patients with acute illnesses such as acute myocardial infarction (AMI), heart failure, and pneumonia. The quality of acute medical care in rural hospitals, however, is not well studied and has focused primarily on process measures. For instance, compared with urban hospitals, rural hospitals reported similar or lower fulfillment rates of process measures of quality for patients hospitalized for the three conditions. Fewer studies have examined patient outcomes, and none has accounted for the clustering of patients within hospitals. When compared with urban hospitals, rural hospitals had higher mortality rates among patients hospitalized for AMI in one study but not in another. Another study found higher mortality rates after percutaneous transluminal coronary angiography (PTCA) among patients hospitalized for AMI at rural hospitals, but similar rates among patients without AMI."

"The absence of a national database and the small samples of patients within many rural institutions



have made it difficult to compare the experiences of patients in rural hospitals and other settings. The recent development of validated risk models, endorsed by the National Quality Forum (NQF) for hospital comparison, to measure hospital risk-standardized mortality for AMI, heart failure, and pneumonia provides an opportunity to compare outcomes in urban and rural hospitals. Our objective was to examine whether hospital-specific, risk-standardized thirty-day mortality for Medicare beneficiaries hospitalized for these three conditions varied by hospitals' geographic remoteness. Each of these conditions is among the most common admission diagnoses among older adults; we studied them to provide a broad evaluation of rural health care quality aligned with IOM priorities."

"**Reassurance for patients, physicians, and policymakers**–Despite concerns about the availability of high-quality health care services in rural communities, we found only a modest relationship between hospitals' geographic remoteness and hospital-specific mortality during 2001–2003. When compared with urban hospitals, the hospitals in more remote small rural areas had an average RSMR 0.5 percent higher for AMI, no different for heart failure, and 0.5 percent lower for pneumonia among FFS Medicare beneficiaries. However, there was a great deal of overlap among remoteness regions, which indicates that **despite the challenges faced by hospitals in remote small rural areas, many perform as well as or better than hospitals in urban areas. Moreover, this spectrum of performance suggests that a hospital's RSMR is not largely determined by its geographic location.**"

"Although some of our findings are statistically significant, the less-than-one-percentage-point difference between urban and remote small rural hospital-specific RSMR provides reassurance for patients, physicians, and policymakers that thirty-day outcomes for three common and important hospital admission diagnoses are fairly similar. The gap between the top and bottom of the RSMR ranges for all hospitals is larger than the difference among hospital geographic remoteness regions, which indicates that quality improvement programs should target all hospitals."

"Despite concerns about the availability of high-quality health care services in rural communities, we found small differences between RSMRs across hospital geographic remoteness regions for AMI, heart failure, and pneumonia. This suggests that improvement in the quality of care will require changes focused at the system level rather than at specific types of hospitals based on geographic remoteness."

Rural Hospitals Work to Attract "Home Grown" Care Givers

RWHC has developed templates for a hospital based "grow your own" "Pre-Employee Educational Loan Program." A "fill in the blanks" loan agreement as well as a draft template of the policy document needed to manage such a loan program is available without any fee for down load at **www.rwhc.com**

Access to Physician Care Increasingly Grim

From "The Physicians' Perspective: Medical Practice in 2008," a survey conducted on behalf of The Physicians' Foundation by Merritt Hawkins & Associates, 10/08, available at **www.physiciansfoundations.org**

"Healthcare is an issue of vital concern to most Americans, and has been in the public conversation nearly every day for years. At a time when both major political parties are calling for expanded healthcare access and a new Presidential administration and Congress are preparing to address the issue, one crucial viewpoint has been largely overlooked: that of the physicians themselves."

"How do physicians across the country see the medical practice environment? How do they feel about the state of their profession, and that of the industry at large? What plans do they have for the future of their individual practices? Do they believe there are enough of them to handle an influx of more patients?"

"The Physicians' Foundation determined to answer these questions, and many more, through one of the largest and most comprehensive physician surveys ever conducted in the United States. Its goal was to give physicians a voice, so that their thoughts, ideas and concerns might be better understood by policy makers, employers, insurance companies and the public at large."

"Through responses provided by approximately 12,000 physicians nationwide that included more than 800,000 data points–as well as through written comments by more than 4,000 physicians–the survey offers a unique and valuable insight into the practices and mindsets of today's doctors."

"The results paint a grim picture that could have drastic implications for the nation's healthcare debate:

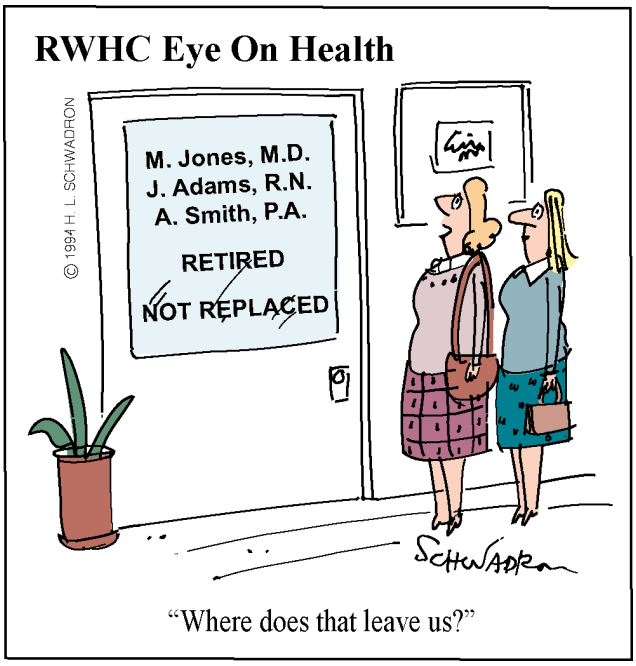
- An overwhelming majority of physicians–78%–believe there is a shortage of primary care doctors in the United States today.
- 49% of physicians–more than 150,000 doctors nationwide–said that over the next three years they plan to reduce the number of patients they see or stop practicing entirely.
- 94% said the time they devote to non-clinical paperwork in the last three years has increased, and 63% said that the same paperwork has caused them to spend less time per patient.
- 82% of doctors said their practices would be 'unsustainable' if proposed cuts to Medicare reimbursement were made.
- 60% of doctors would not recommend medicine as a career to young people."

"Combine these statistics with recent studies showing that medical schools are graduating fewer and fewer students who will choose to become primary care doctors–and the future for both physicians and their patients seems uncertain at best."

"In the years ahead, the condition of America's primary care doctors as a profession will greatly affect the viability of our nation's healthcare system. A

positive and functional system of practices and doctors will ensure a motivated workforce as well as encourage a new generation of quality physicians, while widespread physician disincentive could jeopardize the quality of our medical workforce as well as the number of physicians available to see patients."

"In the words of one physician who responded to the survey, 'something has got to be done, and urgently, to assist physicians, especially primary care physicians' in order to maintain the viability of the medical profession and to ensure timely and effective access to the doctors on whom so many depend."



ferred to home health or skilled nursing facilities, since such post acute care services might be less available in rural areas. Likewise, limited availability of post acute care services could affect a rural professional's performance score for resource use for acute care services…"

It is not clear how this initiative addresses the growing shortage of physicians. Look forward to a fair amount of "discussion" as this moves forward.

Medicare Plans Physician Incentive Program

The Centers for Medicare & Medicaid Services (CMS) has posted "Medicare Value-Based Purchasing Program for Physician and Other Professional Services Issues Paper" on its website at: **www.cms.hhs.gov/center/physician.asp**

The paper is part of the process of developing a plan to transition to a Medicare Value-Based Purchasing Program for physician and other professional services, as required by Section 131(d) of the Medicare Improvements for Patients and Providers Act of 2008.

To the credit of CMS, some rural questions have already been teed up by CMS: **"What should be the basis for receiving an incentive? Are there strategies that place particular types of professionals, such as rural professionals, at an advantage or disadvantage?…"**

"For example, it could be challenging for some rural professionals to meet a national threshold for certain process measures, such as the percent of patients re-

Medicare Experiment Not Going as Expected

From "Medicare's Private Plans: A Report Card On Medicare Advantage" by Marsha Gold, a senior fellow at Mathematica Policy Research Inc. in Washington, DC at **www.healthaffairs.org** on 11/24/08:

"With higher payments and expanded private-plan authority, Medicare Advantage (MA) has caused the market to grow. One in three Medicare beneficiaries with Part D now gets this coverage through MA. Analysis of the sources of and reasons for enrollment growth suggest a troubling report card. Clearly, the Medicare Modernization Act (MMA) has expanded choice and the private-sector role. But it also has added to Medicare's complexity and costs and has created potential inequities, without apparent improvements in quality. However the debate ends, a stronger system of performance monitoring and accountability is needed to meet Medicare's essential fiduciary requirements and oversight responsibilities."

Rural Health Policy Institute–This Year, Be There
Confirmed: Congressman Pete Stark (D-CA), chairman House Ways and Means Committee, Subcommittee on Health
January 26-28th, 2009, Washington, DC
Information at: www.ruralhealthweb.org

Rural Hospital Survival Benefits Community

The RWHC Board of Directors has developed draft language to be considered for inclusion in a non-profit rural hospital's annual report to IRS Form.

Each rural hospital is unique and depending upon a hospital's distance from another hospital, the supplemental narrative text below may make more or less sense to include in a rural hospital's IRS Form 990, Schedule H, Part VI.

This perspective is not intended to justify a hospital avoiding the responsibility of having a robust investment in the diverse array of activities catalogued in various statewide community benefits reports; rural hospitals must do all they can to help their communities become healthier. It is intended to help educate our country about the real value of rural hospitals in case of a future regulatory use of the 990s. The recommended narrative, which should be edited to reflect each hospital's individual situation, is as follows:

"While there is growing agreement in the United States about what constitutes a non-profit hospital's 'community benefit,' this is a work in progress. Our hospital provides significant charity care and other community benefits as defined by the IRS. But in addition, we believe that we provide a critically important community benefit, which is not quantified. Our hospital, like most rural hospitals, was created and is maintained in order to provide care locally–care that without our hospital, would not be available locally."

"Beyond inpatient hospitalizations, we provide local access to many health services: Ambulance Services, Birthing Center, Dialysis Center, Diagnostics, Emergency Services & Urgent Care, Extended Care, Home Care, Hospice, Infusion Services, Inpatient Care, Laboratory Services, Occupational Health, Rehabilitation Services, Specialty Medicine, Sleep Center, Speech and Audiology, Surgical Services, Women Services."

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Community Care in Platteville

We regularly showcase a RWHC member from the Wisconsin Hospital Associations' annual Community Benefits Report. 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 the Southwest Health Center in Platteville:

"A 22-year-old college student, who recently lost her health insurance coverage under her parents' policy, came into the ER due to a viral infection. Since she was a full time student, she worked part time, which covered her basic living expenses. She contacted the patient financial services department with the immediate concern that she would need to quit school to pay for her medical bills. She applied for the hospital's Community Care program and qualified for 100 percent assistance. The student continued with her schooling and looks forward to graduation in 2009."

"A 26-year-old uninsured construction worker was unexpectedly rushed to the ER due to intense abdominal pains. A severe intestinal obstruction was found that required immediate surgery. After a three-day stay, the patient was discharged and returned home. The patient lost income due to several weeks of recovery and was considering filing for bankruptcy due to his unexpected medical expenses. He applied for Community Care and qualified for 100% assistance."

"A 51-year-old recently came to Southwest Health Center with income troubles. Her daughter and granddaughter had to move in with her due to the loss of their home from Hurricane Katrina. She did not qualify for medical assistance and needed some medical treatment for cardiac concerns. Thanks to the Community Care program, the woman was able to get the tests done, receive the required medications and receive therapy to help with her day-to-day living."

"An unemployed 44-year-old having abdominal pains needed some expensive tests ran for proper diagnosis. He did not have insurance. After applying for Community Care program, the patient was able to get the proper testing and diagnosis. Since his diagnosis, Southwest Health Center helped him apply for other medical assistance programs, which he now receives."

WI Health Falls from 4th to 17th in 10 Years

From "Wisconsin drops from No. 12 to No. 17 in United Health Foundation's annual rankings" in the *Wausau Daily Herald*, 12/3/08:

"The high prevalence of binge drinking and low per capita public health spending have dropped Wisconsin's ranking in an annual health survey by the United Health Foundation."

"The high prevalence of binge drinking and low per capita public health spending have dropped Wisconsin's ranking in an annual health survey by the United Health Foundation. The America's Health Rankings puts Wisconsin at No.17. The survey compares states on 20 health measures to determine whether the nation's health has improved or gotten worse. For the fourth straight year, the overall health of the United States' population has not improved; factors such as higher rates of obesity and increasing numbers of people without health insurance played a role."

"Wisconsin dropped five places between 2007 and 2008. Among other factors cited for the decline were:

- Levels of air pollution have increased 7 percent in the last year
- Prevalence of smoking decreased by 6 percent
- The percentage of children in poverty increased 31 percent over the last five years
- The prevalence of obesity increased by 124 percent since 1990"

"The report cited high graduation rates, low rates of people without health insurance and low incidence of infectious diseases as the state's strengths. The foundation has published the rankings each year since 1990." Wisconsin was 4th in 1999; the report is at:
www.americashealthrankings.org/2008/index.html

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www.rwhc.com/Awards/MonatoPrize.aspx