

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

“Reform” Doesn’t Pretend to Have All Answers

From “NOW WHAT?” by Atul Gawande in *The New Yorker*, 4/5/10:

“On July 30, 1965, President Lyndon Johnson signed Medicare into law. In public memory, what ensued was the smooth establishment of a popular program, but in fact Medicare faced a year of nearly crippling rearguard attacks. The American Medical Association had waged war to try to stop the program, and doctors weren’t about to abandon the fight against ‘socialized medicine’ simply because it had passed into law. The Ohio Medical Association, with ten thousand physician members, declared that it would boycott Medicare, and a nationwide movement began. Race proved an even more explosive issue. Many hospitals, especially in the South, were segregated, and the law required them to integrate in order to receive Medicare dollars. Alabama’s Governor George Wallace was among those who encouraged resistance; just two months before coverage was to begin, half the hospitals in a dozen Southern states had still refused to meet Medicare certification.”

“Either boycott could have destroyed the program. Hundreds of thousands of elderly and black patients would have found their hospitals and doctors’ offices

closed to them. But, as David Blumenthal and James A. Morone recount in ‘The Heart of Power,’ their riveting history of health-care politics, Johnson recognized the threat and outmaneuvered his opponents. With the doctors, he cajoled and compromised, giving the A.M.A. a seat on an advisory council that oversaw the rules and regulations, and working with it on a series of thirty ‘improving’ amendments to the legislation. With hospitals, however, the President brooked no compromise. He convened a battle council of top advisers; set Vice-President Hubert Humphrey phoning mayors to pressure resistant hospitals; and deployed hundreds of inspectors to make sure that participating hospitals integrated their wards. There was fury and acrimony. In the final weeks before Medicare’s start, though, the hospitals decided to abandon segregation rather than lose federal dollars. Only then was Medicare possible.”

RWHC Eye On Health



“With reforming health care itself, its not such a bad thing that it is doctors, hospitals and payers who need to figure out how to do it.”

“The health-reform bill that President Obama signed into law last week—the unmemorably named Patient Protection and Affordable Care Act—could prove as momentous as Medicare. Yet, because most of its provisions phase in more slowly than Medicare did, they are even more vulnerable to attack. The context, of course, is different. As Robert Blendon, of the

Harvard School of Public Health, points out, the war against health reform in 2010 has not been an interest-group battle. The A.M.A. endorsed the legislation; hospital associations were supportive. Once the public

option was dropped, most insurers favored the bill. The medical world will wage no civil resistance. This time, the threat comes from party politics. Conservatives are casting the November midterm elections as a vote on repealing the health-reform law. If they regain power, they are unlikely to repeal the whole thing. (No one is going to force children with pre-existing conditions back off their parents' health plans.) Instead, they will try to strip out the critical but less straightforwardly appealing elements of reform—the requirement that larger employers provide health benefits and that uncovered individuals buy at least a basic policy; the subsidies to make sure that they can afford those policies; the significant new taxes on household incomes over two hundred and fifty thousand dollars—and thereby gut coverage for the uninsured.”

“Opponents may also exploit the administrative difficulties of creating state insurance exchanges. The states have four years to prepare, and creating an exchange is, in theory, no more complicated than what states do in providing health-benefit options to public employees. Massachusetts, which has achieved near-universal coverage this way, had its exchange working in six months. Still, with fourteen state attorneys general already suing to stop parts of the reform, some states may refuse to cooperate, forcing a showdown.”

“The major engine of opposition, however, remains the insistence that health-care reform is unaffordable. The best way to protect reform, in turn, is to prove the skeptics wrong. In 1965, health care consumed just six

per cent of U.S. economic output; today, the figure is eighteen per cent. Nearly all the gains that wage earners made over the past three decades have gone to paying for health care. Its costs are curtailing all other investments in the economy, and, if they continue to rise as they have been doing—twice as fast as inflation—the reform’s subsidies, not to mention America’s prosperity, will indeed prove unsustainable.”

“But the reform package emerged with a clear recognition of what is driving costs up: a system that pays for the quantity of care rather than the value of it. This can’t continue. Recently, clinicians at Children’s Hospital Boston adopted a more systematic approach for managing inner-city children who suffer severe asthma attacks, by introducing a bundle of preventive measures. Insurance would cover just one: prescribing an inhaler. The hospital agreed to pay for the rest, which included nurses who would visit parents after discharge and make sure that they had their child’s medicine, knew how to administer it, and had a follow-up appointment with a pediatrician; home inspections for mold and pests; and vacuum cleaners for families without one (which is cheaper than medication). After a year, the hospital readmission rate for these patients dropped by more than eighty per cent, and costs plunged. But an empty hospital bed is a revenue loss, and asthma is Children’s Hospital’s leading source of admissions. Under the current system, this sensible program could threaten to bankrupt it. So far, neither the government nor the insurance companies have figured out a solution.”

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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“The most interesting, under-discussed, and potentially revolutionary aspect of the law is that it doesn’t pretend to have the answers. Instead, through a new Center for Medicare and Medicaid Innovation, it offers to free communities and local health systems from existing payment rules, and let them experiment with ways to deliver better care at lower costs. In large part, it entrusts the task of devising cost-saving health-care innovation to communities like Boise and Boston and Buffalo, rather than to the drug and device companies and the public and private insurers that have failed to do so. This is the way costs will come down—or not.

“That’s the one truly scary thing about health reform: far from being a government takeover, it counts on local communities and clinicians for

success. We are the ones to determine whether costs are controlled and health care improves—which is to say, whether reform survives and

resistance is defeated. The voting is over, and the country has many other issues that clamor for attention. But, as L.B.J. would have recognized, the battle for health-care reform has only begun.”

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centivize. Equally a threat to access is the soon to explode retirement of baby boomers, leading to worsening of the current mal-distribution of healthcare professionals.”

“Given the history of rural health voices being under-represented on the current Medicare Payment Advisory Commission, an even more powerful Medicare Commission is potentially threatening to rural equity and will require even greater vigilance.”

“Health reform’s first installment was the American Recovery and Reinvestment Act and its focus on health information technology. Unfortunately, it appears that many decisions to date, by Congress and the Administration, are leading to an increase in the rural-urban digital divide.”

“The greatest limitation to this legislation is that it is about “healthcare” much more than about “health” reform. Americans are breaking the healthcare bank due to too much smoking, drinking and eating, and too little exercise, education and jobs. We must expand our efforts to help individuals and communities become healthier—to reduce the need for health care.”

The Other Shoe Drops After 45 Years

by Tim Size, RWHC Executive Director, from “11 Health Leaders React to House Passing Health Reform” at www.healthleadersmedia.com on 3/22/10:

“The healthcare legislation that looks headed to the President’s desk is not ideal. It couldn’t be otherwise given our country’s deeply held and contradictory values. But the fact that tens of millions of Americans are uninsured and most of the rest of us are just one lost job from the same dilemma, drove this train. A majority in the Senate, and now the House, have decided they couldn’t lose another generation in pursuit of the perfect bill.”

“I studied with George Bugbee, (the American Hospital Association’s first non-physician executive director) to become a hospital administrator just a few years after the creation of Medicare and Medicaid in 1965. Assuring universal coverage for the rest of America was then widely believed to be right around the corner. It has been a long corner.”

“It took us the greater part of twenty years to work through challenges caused but not anticipated when the Medicare Prospective Payment System began in 1983. It will take at least that long for all of us to digest this new change. From a rural perspective, there are significant priority areas that will need our robust attention.”

“Protecting access to local care is a high priority as we address the systemic changes this legislation will in-

“Sharpening the Axe”

From “Thinking Clearly About Payment Reform”, a Commentary by Robert Gavin in the February, 2010 issue of *The American Journal Of Managed Care*:

“The health reform debate of 2009-2010 has highlighted the consensus that the payment system itself must be reformed. The importance of payment in shaping the healthcare system has long been recognized (e.g., diagnosis-related groups [DRGs] in the 1980s and resource-based relative value scale methodology in the 1990s). **What’s different now is the recognition that payment must be tied to quality, outcomes, and overall cost growth.** This new viewpoint is a triumph for the quality movement.”

“The Center for Payment Reform (CPR), a recently formed organization composed of labor, consumer groups, employers, and providers, and focused solely on payment reform, is in the process of developing a conceptual framework and a glide path to reform the payment system. Although not yet complete, the CPR framework begins with 4 premises, described below.”

Premise 1. “Payment changes should be **evidence based** to the extent possible and there is limited evidence about what works at this point. Although there is some evidence on how changes in payment affect provider behavior, this evidence is insufficient to make widespread assertions about future policy. Accordingly, there needs to be rapid cycle assessment of payment changes (with methodologies that allow for real-time evidence generation), and payment systems should be part of studies of comparative effectiveness.”

Premise 2. “**Substantive alternatives** to the fee-for-service and DRG models **will take a long time** to develop. It is **imperative** that **simultaneous improvements be made so that the current payment system becomes performance sensitive.**”

Premise 3. “**One size does not fit all** when it comes to new payment systems. In any given market, the path from the current payment system to a system based increasingly on value needs to be specific to a locale’s payers, plans, and providers.”

Premise 4. “A model of “**structured flexibility**” needs to be developed to **encourage innovation while reducing confusion.** This model would include (but not be limited to) issues like the standardization of definitions, agreement on which quality and cost measures are acceptable as bases for payment, a common framework for evaluation, and so forth.”

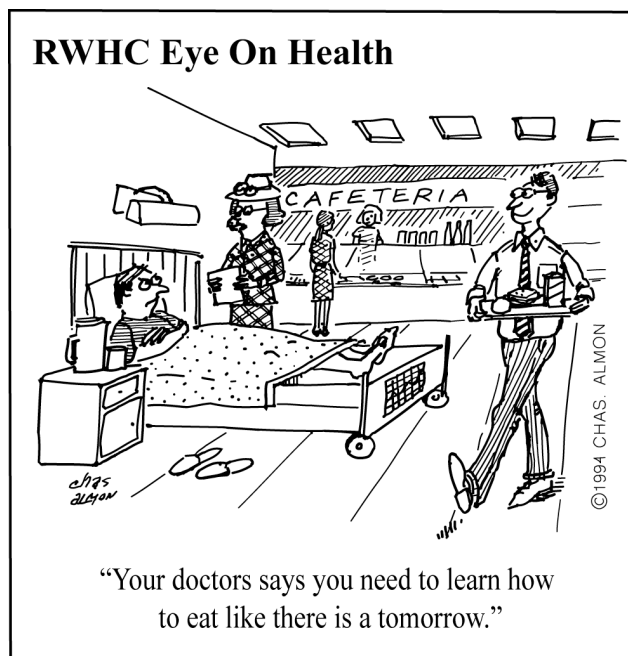
“An agreed-on conceptual framework is key. It’s time to spend the time to define in more detail what we mean by ‘performance-based’ payment and how we

can achieve it in a rational, evidence-based way. In the words of Abraham Lincoln, ‘if I had eight hours to chop down a tree, I’d spend the first six sharpening the axe.’ ”

See www.centerforpaymentreform.org for more information.

Wisconsin Office to Implement Reforms

From a Press Release by the State of Wisconsin, 4/7:



“Governor Doyle announced the creation of the Office of National Health Care Reform to usher the implementation of national health care reform in Wisconsin.”

“DHS Secretary, Karen Timberlake and OCI Commissioner, Sean Dilweg will chair the Office and are charged with developing an implementation plan for national health care working closely with health care stakeholders.”

“The Governor is directing that the office ensure that

Wisconsin’s residents and businesses realize the benefits of national health care reform by doing all of the following:

- Provide transparent access to information so individuals and businesses can make informed decisions on the cost of health care coverage.
- Assess insurance market reforms needed to prepare Wisconsin for final implementation of national health reform in 2014.
- Create a health insurance purchasing exchange to:
 - ✓ Create a virtual marketplace through an easy-to-use, easy-to-understand web-based con-

sumer portal to connect eligible residents and businesses with health insurance options.

- ✓ Provide a single point of access for all eligible residents and businesses to choose their insurance.
- ✓ Promote consumer choice by providing easy comparability of health plans and lower health care premium costs by creating a large pool of employees to increase consumer purchasing and bargaining power.
- ✓ Ensure that the health insurance purchasing exchange is structured to reward highest quality and most cost-effective health care providers and insurers.”

“Provision of a ‘single access point for affordable health care coverage’ means that enrollment for the health insurance purchasing exchange for small businesses will be fully integrated with BadgerCare Plus so that there will be one virtual entry point from which individuals will be directed to the appropriate point for health care.”

“The Office will apply for federal grants to assist in funding the exchange and will launch a website to provide information to the people of Wisconsin on the new health care reform legislation as well as important implementation information.”

“DHS will launch and regularly update a new website <http://www.healthcarereform.wisconsin.gov/> that will provide all Wisconsin residents with information about the new legislation as well as a tracking of Wisconsin’s planning and implementation efforts.”

Proof of e-Savings Remains Elusive

From “Savings From Computerizing Medical Records Are Hard To Measure” by Christopher Weaver in *Kayser Health News*, 4/07/10:

“When it comes to health policy, few ideas find as much bipartisan support as the notion that widespread adoption of health information technology could im-

prove medical care and save money. But putting a realistic number on those savings remains an elusive goal for health IT advocates.”

“A study published yesterday in the journal *Health Affairs* takes another step towards putting a dollar value on those savings. The Department of Veterans Affairs (VA) may have saved up to \$3.1 billion between 1997 and 2007, the researchers report, but that finding is laden with caveats.”

“The report looked at the potential savings—based on the real-world findings of other, narrower studies—across the VA system. The possible dollar amount was based on things like faster access to records for staffers; reduced spending on radiological film; and the drug interactions prevented by electronic records and, therefore, the care not needed. But the researchers made clear that their finding shows only what is possible—not what the VA actually saved.”

“‘We are not certain to what extent [the savings] were realized,’ said Douglas Johnston, the executive director of the Center for Information Technology Leadership and one of the researchers. ‘We would like to have empirical studies. We know the VA is heading that way. It’s our hope that this study would contribute to how to measure health IT value.’ ”

“Johnston speculated that most institutions have only limited funds for self-reflection. While the elusive dollar-value of health IT savings is a charged issue for e-health advocates, the hospital executives who control purse strings may be less interested. That’s changing, Johnston said, in part because of federal stimulus funding that includes evaluation of a \$30-billion-plus federal investment in health IT.”

“In the absence of an empirical savings estimate, President Barack Obama used a report from Johnston’s center to quantify the savings from his then-planned e-health initiative on the 2008 campaign trail. The center anticipated that the entire health system could save \$77.8 billion a year if e-health were ubiquitous.”

“That estimate was central to a critical Washington Post report exploring the tech-industry ties of the Center for IT Leadership’s chairman, Blackford Middleton, who is also an author of the VA report. The Post implied that a potentially optimistic promise of sav-

ings encouraged the White House to back the e-health stimulus funding, which will benefit health providers, as well as software vendors who often have ties to researchers in the tiny health IT world. (Johnston said by e-mail that the Post's report was 'off base,' and that the researchers have 'no financial stake or vested interest in any of the technologies we study.')"

"To be sure, squeezing value out of electronic medical records at all can be a challenge, and **the VA's experience may not tell us much about what smaller hospitals and physician practices can expect.** A separate article in the same issue of Health Affairs recounts a litany of e-health hiccups at a New Jersey primary care practice, including security glitches in e-prescribing and sluggish, user-unfriendly software."

"Indeed, the Congressional Budget Office has been more conservative in estimating the potential benefits. In a report last March, they estimated health IT spending under the stimulus could save the federal government around \$13 billion over the next ten years, and may save the private sector some money as well."

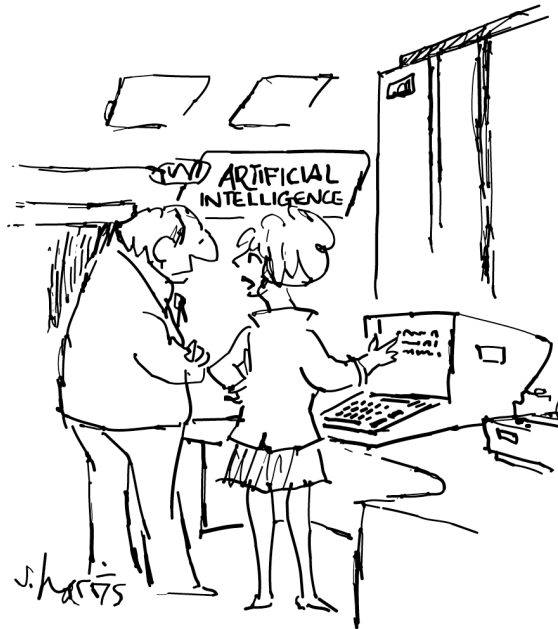
Recruitment Starts With Relationships

From "Health Care Begins in Human Bonds" by Robert Bowman, M.D. at www.dailyonder.com on 3/02/10:"

"Dr. Robert Bowman explains how a community solved the problems of physician recruitment and retention by seeing that the two problems are really one: how to build quality relationships."

"When people focus on quality, the rest falls in place. That was the credo of William Edwards Deming, the

RWHC Eye On Health



"Computers are now even better than humans at overstating their benefit and understating their cost."

20th Century's guru of organizations. A statistician and expert in product design, Deming found that insistence on quality often incurs higher costs at first, but in the longer run costs are lower and the entire system improves."

"A core concept, and my favorite among Deming's ideas, considers quality in 'the matrix of relationships.' This principle is key to health care."

"In many ways our country seems to be instructing the world to de-emphasize the most important human bonds: the earliest parent-child relationships, student-

teacher relationships, the sense of belonging. These connections affirm people in life and ground them in community, family and health. In medical education where a priority should be on relationships, this focus is displaced by attention to academics, sciences, and technology. Instead of assuring that a physician can establish and maintain the most important relationships, admissions and training place too much emphasis on standardized testing."

"What people may not realize is that rising health care costs are often due to inappropriate medical responses to patients' needs—a direct result of weak or non-existent relationships. When physicians have not followed patients for a period of time, when there's no continuity of care, doctors are more likely to miss significant health changes and symptoms."

"What Does Quality Look Like? A standard way of looking at health care systems is via the cost-quality curve: the more investment that that goes in, the better the health care outcome. The concept of managed care was based in large part on the idea of a flattening cost-quality curve: after enough resources are applied, the reasoning went, the quality improvement per unit of resources injected begins to decline. Managed care emphasized compromise, presuming we can get nearly

the same quality for less cost. The focus was more on economics than on true quality and relationships.”

RWHC Social Networking:
The Rural Health Advocate: www.ruraladvocate.org/
Rural Health IT: www.worh.org/hit/

“A few years back a doctor from the Guthrie system in Pennsylvania presented data on physician recruitment and retention efforts. Guthrie had tried a new approach, one that saw recruitment and retention were the same. Administrators began retention interventions at the beginning of the relationship with a new physician and continued to focus on relationships throughout the first months and years.”

“Meetings were set up—initially every few weeks, then monthly—to exchange awareness regarding the new physician’s adjustment and relationships. Guthrie expected improvements in retention, but did not expect quality measures to go up, as well as productivity and patient satisfaction. They all did. Accountants count the cost of ‘giving in’ to physician or to patient requests. But from the perspective of quality, what counts is quite different: a mutually beneficial relationship for all involved.”

“As a person responsible for state recruitment and retention of rural family physicians, I learned to work with an entire state and local team with a focus on trainees, the future rural workforce of a state. I learned to involve the spouses of the residents. Some of our best recruitment functions involved bringing great rural people in need of health care to the same place and time with physician-residents and their spouses—and getting out of the way. Let the courtship begin as each tries for a best fit.”

“I also learned to instruct the family practice residents to examine the recruitment process that they had just experienced. If it had been a process that would help them, in turn, to recruit colleagues and replacements, they should sign the final contract. If not, they should go somewhere else. What I did not realize all along is that the true focus was relationships.”

“The best recruitment that I heard about from a family practice resident faced the problem of retention at the start. The health center

2nd Annual Wisconsin Rural Health Summit
Monday, May 10th, at the Kalahari Resort in Wisconsin Dells

Sponsored by the Wisconsin Office of Rural Health, the focus is on cross sector engagement amongst rural hospitals, rural health clinics, community health centers, rural emergency medical services, long-term care, public health and dental health providers.
Register at <http://www.worh.org/WI-RHSummit10>

administrator met the resident and his spouse, spent about 45 minutes with them discussing their various interests, and then

had a colleague give them a tour. The real purpose was not a tour. The purpose was to give the administrator time to call about six people in town whom he assessed as likely to be able to relate to this potential new doctor and his wife. Over the next days the couple just ‘happened’ to meet these people, and a few more, as the key priorities of the couple were discovered.”

“While this may seem sneaky and self-serving, it also established the beginnings of retention for the physician couple. By the way, the weekend closed with the resident and his spouse taking an active role, singing at the local firehouse. This is not a usually scheduled recruitment activity, but it did help create an important result—a young professional, along with his wife and family, came to serve in the town and belong.”

“As a family physician, my most common challenges have been loneliness and brokenness. These problems have been expressed in physical, emotional, and spiritual terms. Perhaps you were thinking that I was talking about my patients only. Actually the loneliness and brokenness applies just as much to me. But when I have developed relationships with patients, I share their brokenness and their loneliness, and not uncommonly we both experience some healing.”

“Community Care – Providing Relief”

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 story is from Sauk Prairie Memorial Hospital & Clinics:

“Mary Wilson (not her real name) lost her job of 12 years in 2007. In 2008, the apartment she rented flooded and she was forced to find

shelter at her 89-year old mother's house for two months. She dug into her IRA and purchased a three-bedroom trailer to live in. Shortly thereafter, Wilson, now 61, suffered a severe leg break, surgery and four days of hospitalization. While she was at Sauk Prairie Memorial Hospital & Clinics (SPMHC), doctors also diagnosed and treated her for atrial fibrillation, a heart condition that can lead to heart failure or stroke."

"In excruciating pain, Wilson worked her way to the phone and found herself at SPMHC a short time later. 'I had a three-hour surgery to put my bone together with plates and pins,' she said. While I was in the hospital they detected the atrial fibrillation and said I could have had a stroke anytime." All together, Wilson faced more than \$30,000 in medical bills, and quite literally had no means to pay them."

"Still woozy from surgery and anxious about mounting bills, Wilson learned that she qualified for financial assistance through SPMHC's Community Care, a non-profit program that helps 300-500 patients annually by paying a portion or all of their medical bills. In 2008, Community Care awarded \$1.1 million in medical bill relief to patients of SPMHC."



" 'It's a way for the hospital to give back to the community and help people who fall through the cracks,' said Dawn Miller, SPMHC patient financial specialist. 'Some people don't have insurance within our service area and this program is in place to help them out. I've heard people cry with relief and gratitude upon hearing that they qualified for Community Care,' she said."

"Released from the hospital with crutches and a walker, Wilson experienced an outpouring of community concern. Neighbors brought her meals and groceries. The local kennel boarded her dog at a reduced rate for three days. Several weeks later, with her leg still in a boot, Wilson said she is healing and pain free."

Rural Health Travelogue: Malpractice Hits Hot Tubs



Space Intentionally Left Blank For Mailing