Rural Wisconsin Health Cooperative

Eye On Health

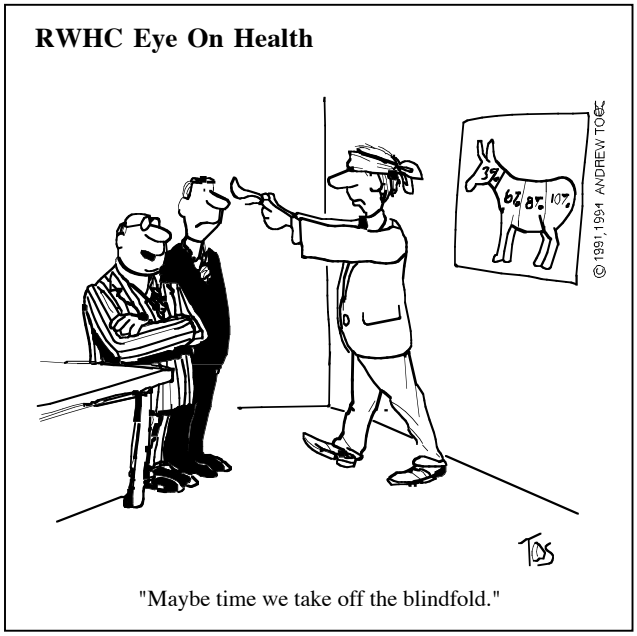
Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2005

"Some Is Not a Number. Soon Is Not a Time"

The Institute for Healthcare Improvement's 100 K Lives Campaign is an excellent way for rural hospitals to begin implementing the findings of the Institute of Medicine's recent report, *Quality Through Collaboration: The Future of Rural Health,* (available at <**http://www.nap.edu/**>). Not all of the Campaign's recommendations are relevant to every rural hospital, but taken as a whole they are. The following is from <**http://www.ihi.org/**>:

"We invite you to join a Campaign to make health care safer and more effective—to ensure that hospitals achieve the best possible outcomes for all patients."

" 'The names of the patients whose lives we save can never be known. Our contribution will be what did not happen to them. And, though they are unknown, we will know that mothers and fathers are at graduations and weddings they would have missed, and that grandchildren will know grandparents they might never have known, and holidays will be taken, and work completed, and books read, and symphonies heard, and gardens tended that, without our work, would never have been.' Donald M. Berwick, MD, MPP, President and CEO, Institute for Healthcare Improvement."



"Maybe time we take off the blindfold."

"**A Flawed System**—Health care is a highly complex system with many broken parts. The good news is that for every broken part in our system, there are remarkable examples of excellence—organizations that have overcome enormous obstacles to redesign the way patient care is delivered."

"Unfortunately, these examples are too few. As the Institute of Medicine (IOM) declared in 2001, in words that still ring true, 'Between the health care we have and the care we could have lies not just a gap, but a chasm.' Health care does not yet reliably transfer best-known science into action, and processes frequently fail, despite the best intentions of a dedicated and highly skilled workforce. Our system, which intends to heal, too often does just the opposite—leading to unintended harm and unnecessary deaths at alarming rates."

"**100,000 Lives**—The Institute for Healthcare Improvement (IHI) and other organizations that share our mission are convinced that a remarkably few proven interventions, implemented on a wide enough scale, can avoid 100,000 deaths over the next 18 months, and every year thereafter. **Hundreds of health care organizations have been making changes that improve care and reduce patient harm. Now is the time to harness those experiences and apply the best methods reliably 100% of the time.** It is time to change; and you can help."

"**The Campaign**—IHI will join hands with other leading American health care organizations in launching an unprecedented ***100,000 Lives Campaign*** **to disseminate powerful improvement tools, with supporting expertise, throughout the American health care system**."

"This campaign aims to enlist thousands of hospitals across the country in a commitment **to implement changes in care that have been proven to prevent avoidable deaths.** We are starting with six changes:

- **Deploy Rapid Response Teams** at the first sign of patient decline
- **Deliver Reliable, Evidence-Based Care for Acute Myocardial Infarction** to prevent deaths from heart attack
- **Prevent Adverse Drug Events (ADEs)** by implementing medication reconciliation
- **Prevent Central Line Infections** by implementing a series of interdependent, scientifically grounded steps called the "Central Line Bundle"
- **Prevent Surgical Site Infections** by reliably delivering the correct perioperative antibiotics at the proper time
- **Prevent Ventilator-Associated Pneumonia** by implementing a series of interdependent, scientifically grounded steps called the 'Ventilator Bundle' "

"Detailed information on each of these six changes is available in the 'Materials' section and will be augmented over the course of the Campaign. In addition to these six changes, IHI will continuously seek and add others that have been shown to save lives."

"Whether a hospital chooses to apply all, or some, of the recommended interventions, their results will be routinely tracked and measured, and will serve as a regular barometer for the Campaign's progress."

"**Get Involved**—There's no cost to joining the *100,000 Lives Campaign*, but your organization must be ready to make some changes and willing to report back on your progress."

"The first step is to sign up—simply go to the 'Sign Up' tab in the Campaign area on IHI's website; you'll find everything you need to know to implement the recommended changes at your institution, including detailed information about each intervention, useful tools, and helpful resources. The site will also feature information on other ways that individuals and organizations can help with the Campaign."

As of February 10th, organizations representing a significant share of Wisconsin hospitals have already agreed to participate:

Aurora Healthcare
Aurora Sinai Medical Center
Bellin Health
Boscobel Area Health Care
Franciscan Skemp Healthcare
Froedtert Memorial Lutheran Hospital
Gundersen Lutheran Health System
Holy Family Memorial, Manitowoc
Hudson Hospital
Luther Midelfort
Meriter Hospital
Monroe Clinic
SSM Health Care
St. Joseph's, West Bend
St. Mary's Hospital Medical Center, Green Bay
St. Mary's Hospital of Superior
ThedaCare

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

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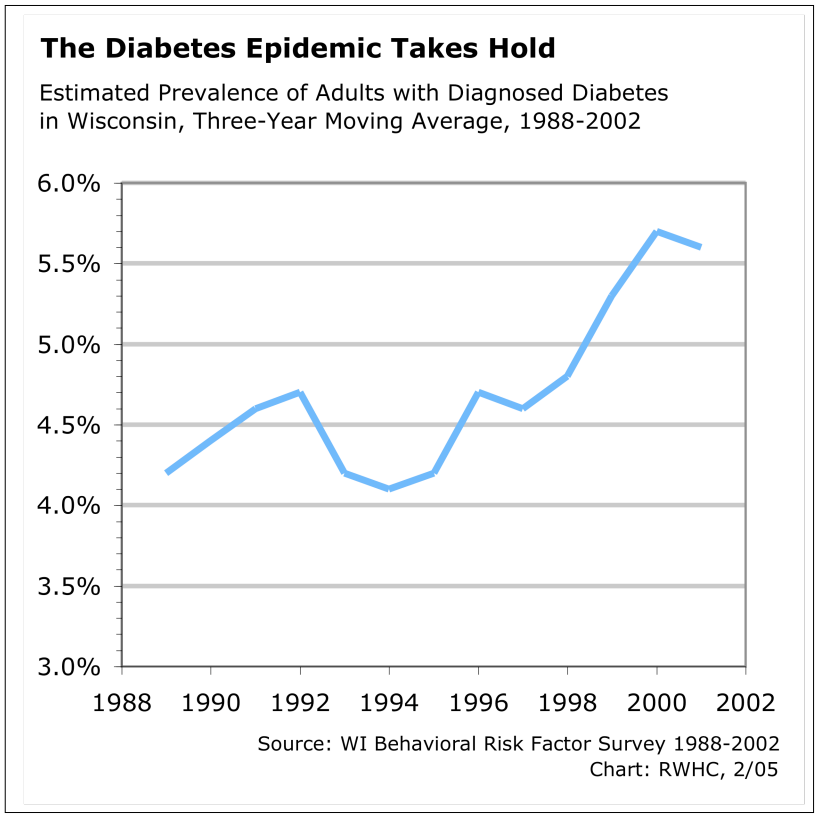
RWHC—Advisory Board Partnership

The Advisory Board Company is an organization of 500 people that provides best practices research and analysis to over 2,500 hospitals across the country. Increasingly, the Advisory Board has focused on business strategies, operations and general management issues that provide very tangible, ROI-driven insights for hospitals of all types.

Their strategic vision is to serve all hospitals of all sizes by crafting unique relationships that support a variety of different needs. While traditionally the Advisory Board membership has been largely comprised of academic medical centers and large hospitals, over the last 24 months they have begun to focus on and dedicate resources to community hospitals. The investment ABC has made is threefold: increasing community hospital membership by 30% to enhance networking opportunities, focusing on research topics that are especially relevant to smaller providers and creating tools to operationalize best practices without a large staff.

On January 31st, 2005, the Advisory Board and the Rural Wisconsin Health Cooperative (RWHC) began a partnership which offers eighteen participating RWHC hospitals access to two of the Advisory Board's programs: the Health Care Advisory Board and the Nursing Executive Center. The partnership supports the hospitals' pursuit of best practices for elevating performance, expediting positive change and building upon the cooperative's current networking opportunities. The relationship allows RWHC members access to Advisory Board meetings, research and materials in unlimited quantities over the coming year. We have great hope for the prospects of this partnership and the power of what our two organizations can achieve together.

For more information about The Advisory Board's community hospital efforts, contact Olivia Millard at (202) 266 6648 or ***millardo@advisory.com***



Diabetes Plan Meaningless Without Action

From the *Wisconsin Diabetes Strategic Plan,* at: <**http://www.dhfs.wisconsin.gov/health/**>:

Why Do We Need A Diabetes Plan?

"Wisconsin has a strong, positive history of working together on mutual, diabetes related issues. It is through extensive collaboration that partners have achieved many broad improvements in diabetes care across the state. In spite of these improvements, much more work remains to be done. Diabetes continues to increase at alarming rates in Wisconsin and across the nation, largely due to overweight, obesity, and physical inactivity. Some children are now developing type 2 diabetes—a disease previously referred to as "adult-onset." Many more people are at increased risk for developing diabetes in the future due to poor eating habits, overweight, obesity, and sedentary lifestyles."

"The good news is that we currently have a good understanding of diabetes and how to control it. Even more exciting is the news that we can take actions to improve our lifestyles,

leading to the delay or even the prevention of this disease in many people. Simple measures, such as healthier eating and increased physical activity, can greatly reduce the risk of developing diabetes. It is imperative for us to take advantage of the latest scientific advances and research and expand statewide diabetes activities to work on both diabetes prevention and control. We must work together to maximize our precious human and economic resources if we are going to be successful in reducing the prevalence and impact of this devastating disease on Wisconsin's citizens and future generations."

"The Wisconsin Diabetes Strategic Plan is intended to serve as a blueprint to help guide collaborative statewide diabetes prevention and control activities over the next five years. It will take the combined efforts and resources of many partners and individuals to achieve a sustained positive impact on diabetes care, prevention, and the creation of healthier communities across the state."

Screening and Prevention

"The American Diabetes Association recently issued new screening guidelines for detecting prediabetes in high-risk individuals. Pre-diabetes can lead to type 2 diabetes and increase the risk of developing heart disease by 50 percent. Lifestyle changes, such as moderate physical activity and consuming a healthier diet, can lead to moderate weight loss and may delay or prevent the onset of diabetes."

The Impact of Diabetes in Wisconsin

Serious—People with diabetes are at increased risk of numerous complications, including heart disease, blindness, kidney disease, and foot and leg amputations. The majority of people with diabetes eventually die from heart disease. Many adverse outcomes of diabetes complications can be prevented or delayed by an aggressive program of early detection and appropriate treatment.

Common—In Wisconsin, approximately eight percent of adults (329,000) have diabetes—six percent (235,000) with diabetes that has been diagnosed and two percent (94,000) with diabetes that has not been diagnosed. Additionally, an estimated 3,000 children in Wisconsin have been diagnosed with diabetes. The prevalence of diabetes has increased in the past decade. Using a three-year moving average, diabetes has increased 33% from 1989 to 2001 (4.2% to 5.6%). Furthermore, an estimated 836,000 persons in Wisconsin aged 40-74 years have pre-diabetes.

Costly—The cost of diabetes in Wisconsin is staggering. In 1998, estimated direct annual costs (medical care) for diabetes were $1.26 billion and estimated indirect costs (lost workdays, restricted activity days, mortality and permanent disabilities) were $1.54 billion, totaling $2.8 billion.

Call to Action, How to Get Involved

"The Wisconsin Diabetes Strategic Plan is a call to action, urging all to take a role in reducing the burden of diabetes in Wisconsin. To achieve these goals, many partners will need to apply different and creative solutions to change system, community, and individual behaviors. It will take active involvement by public and private partners to ensure that priority areas in diabetes are addressed. Statewide groups will need to work to affect state and national level policy changes that support initiatives developed in this plan and individual residents of Wisconsin will need to take action to change their own environments and behavior."

"Diabetes is a serious, common, costly, and growing problem that cannot be solved by a single organization, group, or individual. By working together, we can develop action steps that may prevent or delay the onset of diabetes in Wisconsin residents and improve care for those individuals already living with diabetes."

What You Can Do

1. "Review the Plan, Goals, and Recommendations. Identify specific items with which your organization may be involved or plan to address."

2. "Make a commitment. Become a partner with the Wisconsin Diabetes Prevention and Control Program and others in preventing and controlling diabetes.

3. "Register your endorsement of the Plan. Registration is open to anyone with existing activities, new ideas, or simply an interest in being involved."

4. "Team with other Plan registrants or groups in your community who share your goals. Foster viable collaborations and partnerships at all levels."

What Does It Mean to Endorse the Strategic Plan

"After you endorse the plan, your name/organization will be acknowledged on the Plan web site and in Plan-related promotional materials, but your contact information will remain confidential and not used for any other purpose. As partners register, the DPCP will track the activities taking place in Wisconsin and identify the areas where additional work is required. The DPCP will also assist with evaluation of the Plan and, based on the results of the evaluation, make suggestions for future actions."

To endorse the Strategic Plan, print out and complete the form on page 33 of the web copy of the plan and fax the form to Judy Wing at (608) 266-8925.

Competitors Collaborate to Take on Diabetes

From *Addressing Chronic Conditions Through Community Partnerships: A Formative Evaluation Of Taking On Diabetes* by Susan E. Palsbo, Thilo Kroll, and Melissa McNeil, A Commonwealth Fund Field Report, 9/04:

"Community partnerships—coalitions of health plans, physicians, and local groups—can help overcome organizational boundaries and allow competing parties to work together to focus on a shared goal, like the treatment of a chronic condition. In this study, researchers evaluated three community partnership projects sponsored by a national trade association of health plans. These initiatives, focused on quality improvement in diabetes care, were located in three very different markets in the United States: Albuquerque, New Mexico; Kansas City, Missouri; and Westchester County, New York. Successful community partnerships, the researchers found, can be formed from different starting points and by following different paths. Instead of following a strict set of protocols, the researchers suggest that these groups pay careful attention to principles of group dynamic theory. In addition, a neutral facilitator, like a trade

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association, can build bridges and help competing concerns be less proprietary." Their recommendations are as follows:

Establishing the Partnership

- "Identify an unbiased facilitator.
- Identify an active coordinator.
- Recruit at least one strong local champion.
- Build consensus from the ground up.
- Obtain agreement among participants that there is a clear need for communitywide intervention.
- Be sure participants are willing to work on mutual objectives.
- Include unrestricted funding (even small amounts) and allow the partnership to decide how to spend it.
- Require in-kind or financial contributions from each participant, so they become vested in project."

Sustaining the Partnership

- "For the first project, design a visible, clearly beneficial, low-cost intervention that may be accomplished within 12 months (e.g., community-wide practice guidelines).
- Appoint or hire a local site coordinator.
- Ask for expert assistance when needed.
- Build an evaluation plan into projects.
- Design a long-range plan with intermediate goals that provide early success.

- Gain visibility for the successful implementation of various projects."

Creating a Successful Intervention

- "Be consistent with the work of other health care quality players (e.g., quality improvement organizations, state department of health, purchasing coalition, or medical society initiatives);
- Build inter-organizational links and foster group cohesiveness;
- Impose minimal, extra administrative and financial burden on participants;
- Leverage existing interventions."

A Dialogue on Rural "Pay-For-Performance"

The following is a summary of a dialogue on "Pay-For-Performance" at a recent meeting of the Rural Wisconsin Health Cooperative Board of Directors with Chris Queram, Chief Executive Officer, of the Employer Health Care Alliance Cooperative. Chris is a member of the Institute of Medicine's Committee on Redesigning Health Insurance Benefits, Payment, and Performance Improvement Programs and requested the opportunity to hear RWHC member thoughts:

Considerations re Design of Performance Incentives

- To the maximum extent possible, physician and hospital incentives should be linked or integrated. The rural challenge is that physicians frequently practice in corporations that have no financial connection to the hospital. In communities where physicians are hard to recruit, the balance of "power" between the medical staff and the hospital CEO and board may be different than in the typical urban setting.

- Performance incentives must be tied to measures/care processes that are relevant to the types of conditions and care systems/processes that are prevalent in rural settings. "Few things are more stress inducing than holding individuals accountable for something over which they have minimal to no influence.

- Performance incentives should also extend to patients so as to ensure the behavior changes that may be needed to achieve certain performance targets. There is significant concern that average patient compliance varies significantly with socio-economic status, as does the cost of intervening to improve patient compliance.

- The size of the incentive should constitute a meaningful 'risk/reward' proposition (perhaps as much as 10%); however, it may be desirable to approach this level in stages over a multi-year period. Consideration of the likely impact of an incentive needs to be calculated not from the perspective of an individual payer but from the aggregate impact of one or more participating payers on an individual provider's bottom line. I.e., a 10% incentive from a payer with 1% market share is significantly less of a carrot than a 2% from a payer with 30% market share.

- Many rural facilities are designated a "critical access hospital" which by statute, receive 101% of allowable costs; performance incentives should be designed so as not to disrupt or end this designation. Excluding them from such programs reinforces negative stereotypes.

- Performance incentives should be designed to encourage the provision of care in the most appropriate setting (e.g., "keep care local") along with assuring safe transfers when clinically indicated.

- Proper attention must be given to methodological considerations (for example, volume/denominator issues), so as not to disadvantage/misrepresent rural facilities. E.g., there is a concern that the public tends to inappropriately interpret a statement of "no data available" or "not applicable" as a statement of lower quality.

Other Questions/Issues

- Incentives should also include a provision to support the "infrastructure" needs of rural facilities (e.g., capital to help sustain access to basic services, acquisition of IT, etc.); there is a major concern (as in the "No Child Left Behind" federal public education initiative) the "poor (hospital/clinic) getting poorer."

- The design of the incentive may need to vary depending on whether the financial component is "new" money or a reallocation of existing reimbursement.

- An area worthy of consideration due to its broad applicability in rural settings is "patient transfer" (including the impact of EMT v. paramedic-level staffing). The deteriorating condition of historically voluntary rural EMS systems across the country is a major confounding variable.

Boomers Not Quickly/Quietly into the Night

From "The Selling of Retirement, And How We Bought It" by Marc Freedman in *The Washington Post*, 2/6/05:

"America finds itself in the midst of a demographic revolution, propelled by the aging of 78 million baby boomers. By 2030 these individuals will make up between 20 percent and 25 percent of the overall population. A wave of 'greedy geezers,' some policy experts say, threatens to break upon us and wash away our fiscal health. While the full force of these demographics has yet to be felt, there is a degree of consensus in much of the current debate over Social Security and national savings: Graying means paying—for those of us who are younger."

"However, those who simply pair up the old lifestyle with demographic trends and declare that social insolvency lies ahead fail to understand that another transformation is unfolding in front of us."

"The gift of longevity is behind the new shift in the way people think about retirement. In 1900 the average American lived to the not-so-ripe age of 47. Today that number is 77, and rising. And that's long enough for retirees to get bored. How much golf can you play?"

"As a result, now people seldom think of retirement as a final stage of life but rather as an interlude between stages. More and more individuals are 'retiring' for a period to catch their breath before making the transition to a new chapter in life. Surveys show that the ideal of the golden years is going into eclipse."

"But what's next for these individuals, many of whom face an identity crisis when they think about the future? Are they senior citizens? Elderly? They don't feel that way. Neither young nor old, they are finished with midlife, yet they can look forward to the likelihood of decades of vitality before becoming truly old. What might they rightly aspire to in the next phase? How will they define success?"

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"So we agree, 'Grey Warriors' replaces 'Greedy Geezers.' "

"While much about the evolution of goals and purpose of this period of life remains unclear, a central, defining feature is emerging. It is work. The vast majority of the boomers plan to continue working -- full-time, part-time, paid, unpaid—in their so-called retirement years. According to a recent study by the AARP, nearly 80 percent of boomers are planning to continue in paid labor during their sixties and seventies. Already we've witnessed an uptick in the percentage of people over age 65 who choose to keep working."

"This new generation of aging boomers seems poised to swap that old dream of the freedom *from* work for a new one built around the freedom *to* work—in new ways, on new terms, to new ends. Indeed, inklings of such a vision are already appearing."

"Consider a recent ad campaign from Home Depot and AARP announcing a new partnership to recruit older workers for the home renovation giant. Targeting men (and perhaps some women) who couldn't

wait to get home from their midlife work to get to the toolshed, the campaign beckons them to trade in retirement for a new vision of what work can be. The slogan: 'Passion Never Retires.' "

"Fidelity Investments offers its own take. In a series of ads, the financial services company features an aging boomer in front of a classroom, graying temples, full of engagement. The message at the top: 'What did you want to do before you started doing what you're doing?' A few years ago, the Del Webb company even opened up a new Sun City outside not-particularly sunny Chicago, prompted in part by research showing that aging boomers want to remain near opportunities for continued work."

"The trend is, of course, welcome news—and not just for the public coffers. We now know that work is good for aging individuals themselves, for their health as well as their wallets. At the same time the nation faces the prospect of a labor shortage in many areas over the coming decades. In the end, reinventing retirement will take more than marketing, more than coining today's equivalent of the golden years—more even than retooling Social Security. It will require a new generation of policies, pathways and priorities."

"A tall order, but the history of aging in America is one of innovation. Social Security and Medicare were invented out of whole cloth within the past 70 years. We didn't even have retirement communities or senior centers 50 years ago. In just half a century, we managed to redefine aging so thoroughly that the "golden" years image seemed as natural as air."

"Now, just 10 months before the first of tens of millions of baby boomers begin to turn 60, we need a transformation no less bold. We must create an aging America that swaps the old leisure ideal for one that balances the joys and responsibilities of engagement across the life span. And that could produce a society that works better for all generations."

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