



## Next Generation Can't Afford Our Inaction

This excerpt is from "A Pay-for-Population Health Performance System" by David A. Kindig, MD, PhD, in *JAMA*, 12/06/06; the complete commentary can be found at <<http://jama.ama-assn.org/>>.

"*Rewarding Provider Performance*, just released by the Institute of Medicine, concludes that early experience with pay-for-performance has been promising and recommends that Medicare begin to phase in this strategy to foster comprehensive and system-wide improvements in the quality of health care. While the effectiveness of pay-for-performance in medical care has been evaluated in fewer than 20 studies and the conclusions on its impact have been mixed, the need for reform is so great that beginning to move cautiously in this direction is widely endorsed."

"But improvements in the quality of health care alone will be inadequate to significantly improve population health. A decade ago I asserted that 'population health improvement will not be achieved until appropriate financial incentives are designed for this outcome' and proposed a 20-year timetable, which would begin with pay-for-performance in medical care but then move on to develop such incentives for the nonmedical determinants of health. As pay-for-performance in medical care moves ahead, it is now time to take up the admittedly more difficult challenge of developing a 'pay-for-population health per-

formance system' that would go beyond medical care to include financial incentives for the equally essential nonmedical care determinants of population health. To lose several generations of greater overall health and diminished disparities is unacceptable when it is apparent that a more balanced health investment portfolio will produce greater returns from these investments."

## "Pay-for-Performance in Medical Care Alone Will Not Improve Population Health—

The health of the US population is far from optimal, both in terms of mean outcomes compared with other nations and in the unacceptable disparities within the country. The United States currently ranks 25th in women's life expectancy at birth among developed nations. The mortality rate for blacks is 31% higher than the mortality rate for whites. The percentage of persons reporting fair to poor health is 6% for persons above the poverty line and 20% for those in poverty."

### RWHC Eye On Health



"Despite relatively poor health outcomes, medical expenditures in the United States are significantly higher than those of healthier international counterparts. Even within the United States, Miami spends twice as much on medical services than Minneapolis, with no difference in health outcomes."

"The second and probably more important reason is that broad population health outcomes are not the result of only medical care but of many other determinants. Population health is also determined by factors in the social environment (e.g., education, income,

occupation), the physical environment (e.g., air and water quality), the built environment, individual behavior, and genetics. While pay-for-performance demonstrations have been under way in the medical care sector, population health and social epidemiology also have been emerging as companion new disciplines. Although research cannot yet precisely quantify the contribution of each determinant, socioeconomic status and individual behavior may be at least as important as medical care in producing these outcomes. Therefore, the medical care sector cannot be held wholly accountable for broad health outcomes—it can only do what it is designed to do and has responsibility for.”

**“Promise of Pay-for-Population Health Performance**—This leads inexorably to the pay-for-population health performance challenge of how to apply financial incentives to health outcomes when those outcomes are the result of a diverse set of sectors and agents that work primarily in isolation from one another. No single agent in either the public or private sector is responsible for population health so accountability is diffuse. However, if the challenge is daunting, the promise is well worth the pursuit—to increase the average health of the US population and reduce disparities while controlling medical care costs.”

**“Challenges of Pay-for-Population Health Performance**—There are many significant challenges to moving forward with pay-for-population health performance. Some of the challenges are identical to those in medical care and others are even more com-

plex... There is no consensus on how to measure population health and its improvement... If reallocation is required, powerful forces within medical care will be unleashed, with predictable conflicts... How then will silos currently separated by dominant forces of culture, incentives, professionalism, and competition be linked... Beyond resistance to reallocation of resources, another potential problem is being drawn to meet today’s need over tomorrow’s, such as treating the injured before working to prevent the injury.”

“Many observers of public and social policy would say that these obstacles are too great to overcome. But what is the alternative? How can public and private policy makers afford not to work to fundamentally improve health and lower future demand for medical care? It certainly will not be easy. But just as pay-for-performance is not perfect, neither will pay-for-population health performance be. Full potential for improving population health cannot be achieved without first developing appropriate financial mechanisms. However, not nearly enough academic and policy debate, time, and money are being devoted to this challenge. Voluntary efforts are not powerful enough to achieve this on a soft money basis.”

**“Now is the time to explore possibilities that go beyond medical care determinants and to fund promising demonstration programs that will help determine the way to overcome obstacles.** Perhaps major foundations should begin a ‘rewarding population health results’ program in which community leaders from a variety of sectors can experiment with promising ideas. **The best places to test these mechanisms may be in rural areas and in smaller states, where the scale is more manageable and where leaders in different sectors may know each other better and perhaps can more easily address and overcome silo issues.”**

“Many determinants, such as education, the environment, and preventive medical care, take generations to achieve their effects. A decision not to move forward is a decision to waste potential years of good health that are achievable. What might be the result if market forces were aligned to produce health instead of primarily the medical care inputs into health? Can the next generation afford for the current generation not to start paying for population health performance?”

The **Rural Wisconsin Health Cooperative (RWHC)** was begun in 1979 as a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of 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.

Tim Size, *Eye On Health* Editor  
RWHC, 880 Independence Lane, PO Box 490  
Sauk City, WI 53583

<mailto:office@rwhc.com>

<http://www.rwhc.com>

*For a free electronic subscription, send us an email with “subscribe” on the subject line.*

---

## Big Business Embraces Prevention Imperative

---

The National Business Group on Health is “an association of 245 large American businesses, including 60 of the Fortune 100. The Board of Directors and the staff of the National Business Group on Health target the key issues of health care costs and quality and provides a mix of short term tactical tools with longer term strategic initiatives.”

They have announced the publication of *A Purchaser's Guide to Clinical Preventive Services: Moving Science into Coverage*, an important resource on preventive services. Developed in collaboration with the Centers for Disease Control and Prevention (CDC), the *Purchaser's Guide* “translates clinical guidelines and medical evidence into lay terms, providing large employers with the information they need to select, define, and implement preventive medical benefits.” Download the free *Purchasers Guide* at:

<http://www.businessgrouphealth.org/>

“The *Purchaser's Guide* arrives at a time when the prevention of disease, injury, and disability is more important than ever. The U.S. healthcare system is in crisis; while the United States has the world's highest annual healthcare costs, it ranks far below most other industrialized nations on measures of population health. Furthermore, research has shown that nearly half the care Americans receive is not aligned with either evidence-based medicine or clinical guidelines.”

“Employers understand the need to prevent illness and disability if they are to have a healthy, productive, and engaged workforce. Each year, millions of Americans die of preventable illnesses and injuries that were caused by modifiable health behaviors. Researchers estimate that 75% of all healthcare costs stem from *preventable* chronic conditions such as type 2 diabetes and hypertension. Many of the leading causes of short- and long-term disability such as kidney disease, some types of cancer, and complications of pregnancy are also preventable. Preventable health problems result in substantial indirect costs for employers in-

### Medicine in Search of Meaning... a spiritual journey for physicians

by rural health's favorite Milwaukian, Bill Bazan, has been republished due to physician and caregiver requests; what they've said:

“Offers a penetrating perspective on which to begin the transformation of the practice of medicine.”

“Reflects a side of medicine overlooked in medical school and residency programs.”

“Rekindles hope for a future in the practice of medicine.”

“Offers practical insights into the relationship between religion and spirituality to enrich the clinical experience.”

Medicine in Search of meaning is a wonderful, stimulating and self reflective book that will assist physicians and other health care providers rekindle their passion for medicine and the patients they serve during times of tumultuous change in the health care environment. Bill Bazan brings the business of the caregiver's heart and soul back into the world of medicine.

As Vice President, Metro Milwaukee for the Wisconsin Hospital Association, Bill has worked with hundreds of caregivers and physicians over the past 15 years. He is a much appreciated featured speaker at many physician and caregiver conferences nationally.

Available directly from the author for \$19.95 + \$5.00 S&H; send remittance with your name and address to Bill Bazan, 927 West Glendale, Milwaukee, WI 53209. For multiple copy pricing contact Bill at 414-431-0105 or [<bbazan@mailbag.com>](mailto:bbazan@mailbag.com).

cluding lost productivity, absenteeism, and turnover. For some conditions, like alcohol misuse, which costs American businesses \$134 billion each year, indirect costs outpace direct treatment costs.”

“Disease prevention and early detection hold the promise of improving our nation's health and reducing healthcare costs. Clinical preventive services help people avoid disease by reducing their health risks. Clinical preventive services can also catch disease in its early stages when interventions are more effective and less expensive. Preventive services have been poorly defined in employer-sponsored medical benefit plans and coverage for preventive services has been less robust than that for acute care services. Differential coverage and a lack of emphasis on



RURAL HEALTH CAREERS  
WISCONSIN

#### Wisconsin Resource: Worksite Wellness Resource Kit

The Worksite Wellness Resource Kit is a tool to assist work-sites with implementing strategies that have been proven to be effective. The kit provides information to implement a broad range of strategies or programming: some will require very little or no resources. The kit shows you ways to get started and make a difference in the health of your employees, regardless of the size of your worksite and its available resources.

<http://dhfs.wisconsin.gov/health/physicalactivity/index.htm>

prevention have resulted in the underutilization of important clinical preventive services such as tobacco use treatment and colorectal cancer screening.”

“Increasing our investment in high-impact and cost-effective preventive services will turn the promise of improved health and reduced cost into a reality. All purchasers need to devote more attention to prevention in order to curb the caseload and costs of chronic conditions. In the current resource-constrained environment purchasers should cover and promote the most beneficial preventive services. The *Purchaser’s Guide*, built upon sound evidence, presents the National Business Group on Health’s recommendations for preventive service benefits and provides tools employers can use to evaluate and expand their current preventive service offerings.”

---

### Practical Guidelines for Employee Wellness

---

The prior article talks about The National Business Group on Health *Purchaser’s Guide*; the section that might be the most interesting to many readers is “Part 6: Leveraging Benefits: Opportunities to Promote the Delivery and Use of Preventive Services” which presents actions employers can take to strengthen prevention efforts by supporting or implementing public health interventions that may occur in the workplace and in communities. An excerpt follows from a section on “General Advice to Employers about Health Improvement and Maximizing the Value of Health Coverage”:

“Employers can ensure health improvement; at a minimum, an employer’s healthcare strategy should:

1. Educate beneficiaries about the importance of clinical preventive services and healthy lifestyles.
2. Encourage beneficiaries to use their covered preventive services appropriately.
3. Support community-wide disease prevention and health promotion activities.”

“To promote the appropriate use of clinical preventive services among beneficiaries, employers should:

- Provide referrals to community-based support services and prevention programs, as needed (e.g., tobacco quitlines).
- Encourage health plans to promote clinical preventive services.
- Encourage providers to increase the use of appropriate preventive services (e.g., time-appropriate reminders to patients).
- Increase preventive service access points (e.g., worksite immunization programs).”

“To more broadly promote health among their beneficiaries, employers should:

- Make prevention information, data, and recommendations available to employees and families.
- Support employee participation in programs of clinical or community prevention (e.g., incentives).
- Support healthy worksites (e.g., offer a healthy cafeteria program).
- Support evidence-based health policies (e.g., require smoke-free workplaces).”

“To promote health generally, employers can:

- Work to increase awareness of health problems among employees, health plans, providers, beneficiaries, other purchasers, and the general public.
- Provide in-kind or financial support to develop or continue evidence-based health programs and policies benefiting broader communities. Consider:
  - Sponsoring or providing supplies for school health programs.
  - Partnering with other business and community agencies to develop environmental health promotion strategies (e.g., changing the physical environment by creating walking and biking trails, encouraging increases in cigarette taxes and banning of cigarette smoking in public spaces).



- Promote public policies that aim to prevent illness, injury, and death (e.g., minimum legal drinking age laws).
- Encourage employees to participate in health promotion programs available in their communities.”

*“What has become clear to me is that the story of public health is not simple to tell. Public health is so broadly involved with the biologic, environmental, social, cultural, behavioral, and service utilization factors associated with health that no one is accountable for addressing everything.”*

**Bernard J. Turnock, University of Illinois at Chicago**

## Hospitals & the Public’s Health

The following is an excerpt from the “Report of the National Steering Committee on Hospitals and the Public’s Health” prepared by the Health Research and Educational Trust (HRET), 9/06.

**Introduction**—“Designing a strong and cohesive system to attend to the public’s health requires an understanding of both the status quo and the future potential for the system’s various parts. Since 2002, HRET has worked with the support of the Centers for Disease Control and Prevention to understand and inform hospitals’ unique contributions to public health improvement.”

“HRET convened the National Steering Committee to guide us in our examination and identification of the role of hospitals in health promotion and disease prevention. Our specific aim was to illustrate why and how hospitals and health systems can be better integrated with the public health system. In return, the National Steering Committee charged HRET with issuing a call to action directed at policymakers and practitioners to incite fundamental change—to guide hospitals’ and health systems’ engagement in improving the public’s health and to eliminate the barriers that systemically preclude this engagement in standard practice.”

**Executive Summary**—“The U.S. health care system is broken. Many hospital executives face nearly insurmountable challenges with respect to limited reimbursement, overburdened emergency departments,

**National Rural Health Association**  
30<sup>th</sup> Annual Conference: May 16-18, 2007  
**ANCHORAGE, ALASKA**  
<http://nrharural.org/>

*“In days past, if the rate of asthma shot up in a community, the local hospital might ask itself how it could become a center of excellence for treating asthma. Today, the same hospital has the responsibility to ask: Why do we have so much asthma and what can we do about it?”*

**Paul Hattis, Tufts University School of Medicine**

treatment for the uninsured, onerous regulations, patient safety and medical liability concerns, reporting and community benefit requirements, and staffing shortages. **The year 2006 may not seem an opportune time to ask more of hospital leaders, yet that is precisely the goal of this report.**”

**“The National Steering Committee on Hospitals and the Public’s Health is calling on hospitals to fulfill a critical role as collaborators and leaders in recreating the U.S. public health infrastructure and capacity.** Why should hospitals participate in this endeavor? The short answer is that they have a vested interest in their communities’ health, and frankly, they cannot afford to maintain the status quo.”

“The old models of medical care and public health delivery no longer work. Our nation spends \$1.8 trillion a year on health care, yet ranks 37<sup>th</sup> out of 191 countries

on eight health outcomes tracked by the World Health Organization. Seventy-five percent of health care spending is on preventable diseases that rob millions of Americans of quality life-years and deprive society of productive citizens. We can save billions of dollars that we currently spend treating avoidable communicable and chronic diseases, if we invest instead in illness and injury prevention.”

“The public health system is the totality of public health departments, emergency response organizations, governmental agencies, hospitals and health care providers, pharmaceutical companies, social service organizations, religious institutions, and many other entities whose common goal is ensuring a healthy population. Until the terrorist attacks on the United States on Sept. 11, 2001, public health departments suffered from a near-fatal lack of funding. In response to the attacks, the federal government has spent billions of dollars during the past five years to resuscitate specific components of the public health infrastructure needed to fight a looming new threat: bioterrorism.”

“Public health services are best delivered at the community level, but the majority of public health departments lack funding, information technology, and staff to adequately provide disease surveillance and protection to their constituents. Moreover, despite huge infusions of funding from the federal government, public health agencies are ill equipped to respond to bioterrorism and natural disaster threats. With decreasing budgets, many cannot perform traditional public health functions. Finally, determinants of disease include environmental, economic, and social factors that originate outside the purview of public health agencies.”

**“It will take a multi-sectoral effort to improve population health at the community level. Business and labor have economic interests in improving workers’ health.**

Schools are interested in improving the health of children, and thus family and community health. The public pays directly and indirectly for increasing health care costs attributable to declining population health status. Americans pay taxes to support Medicaid and Medicare. Those who are fortunate enough to have health insurance pay higher insurance rates due to cost shifting to cover medical treatment for the uninsured and underinsured. For these and other reasons, we all have economic and personal interests in improving the health of our communities.”

“The National Steering Committee is calling for change and innovation—for hospital leaders to help public health leaders define and develop a new public health system to improve Americans’ health. Mutual respect and cooperation must guide efforts to recreate the public health infrastructure. **The ideal is a partnership in which each member does the work for which it is best suited and supports the other in its work. Private and public health must engage in active dialogue and joint action to ensure the public’s health.** Rather than act in isolation, they must do a better job collaborating to advance the mutual goal of improving the health of people in local communities.”

“Most hospitals have already participated in bioterrorism preparedness planning and preparation with public health and emergency medical services partners. Hospitals collaborate with these and other agencies and organizations to meet the challenge of planning for and responding to a mass casualty event such as terrorism, a natural disaster, or a pandemic. Despite all the planning efforts, hospital CEOs recognize that many linkages are still missing with respect to disaster planning, as revealed before, during, and after Hurricane Katrina.”



**“This report calls for a new paradigm: Hospitals must look beyond their walls and the immediate sick.** This new system of American health care requires a realignment of financial incentives—in both the public and private sectors. It contains an introduction to the American health care crisis and a detailed discussion of the role hospitals can and must play in changing the system and improving Americans’ health. The National Steering Committee makes seven recommendations in areas where

hospital leadership and involvement are urgently needed:

1. Eliminate health disparities
2. Coordinate care
3. Promote primary prevention
4. Optimize access to care for all
5. Advocate payment for prevention
6. Build the community’s capacity to stay healthy
7. Support recreating the public health infrastructure and expanding capacity”

“Under each recommendation, guidance is provided on how hospital leadership can focus on and deliver new strategies for institutional involvement in these critical areas that affect the public’s health. This report is intended to be used by hospital senior management and hospital trustees to:

- Assess current hospital practice with regard to the seven recommendations;

- Provide concrete actions that hospital leadership can take today;
- Identify issue areas for hospitals and health partners to advocate needed change; and
- Provide resources for hospitals to use to improve the public's health."

---

## Hatfields & McCoys Can Partner

---

The following is from *Collaboration: Modern Relationships Between Rural Community Health Centers and Hospitals* by Michael E. Samuels & Shelly Ten Napel, 2005, and is available as a free download at <http://www.nrharural.org/>.

"This report highlights successful models of collaboration between health care providers in rural communities. Each of the model collaborations includes at least a Community Health Center (CHC) and a rural hospital, though most are also integrated with other parts of the rural health delivery system as well. The National Rural Health Association has worked to develop this report because it believes collaborative models of care can improve the quality of health care for rural residents and strengthen the local health care infrastructure."

"Collaborative health care is uniquely *possible* in rural areas because the rural health care system normally has fewer providers who are less likely to be in competition for patients. It is uniquely *necessary* in rural communities to ensure efficiency and prevent costly and unneeded duplication of administrative services and overhead costs. Collaborative models are *timely* because they are in line with the larger quality movement—particularly, the movement toward coordinated chronic disease management—currently being promoted by the Institute of Medicine and other quality advocates."

"Five successful collaborations between rural Community Health Centers (CHCs), rural hospitals, and other rural health care service providers were examined. The report discusses ways the collaborations developed, identifies some of the catalysts and hurdles, describes the nature of the collaborations, and highlights some of the benefits that have been realized."

"The purpose of identifying successful collaborative models is to:

- Show innovative care delivery models already underway in rural America
- Demonstrate that collaboration is possible and beneficial
- Provide some practical ideas for communities seeking to better coordinate their health care delivery services"



"There is widespread agreement in the health policy community that a more integrated health care system is an important goal. This report shows several cases where rural communities are leading the way toward this objective by implementing successful models that work. In fact, some of the highest quality health care in the country is already being provided in rural communities across America.

Rural health care consumers should expect this type of quality and demand it if it does not currently exist."

"The following five collaborative models were identified for study, based upon the diversity of the model, diverse rural locations, and the services provided:

- *Jeraud County Clinic* (CHC) and *Avera Wesskota Memorial Medical Center*, Wessington Springs, **South Dakota**
- *Northern Counties Health Care, Inc.* (CHC) and *Northeastern Vermont Regional Hospital*, Saint Johnsbury, **Vermont**

- *Northern Care Collaborative, Inc.; Alcona Citizens for Health* (CHC), Lincoln, Michigan; *Thunder Bay Community Health Services, Inc.* (CHC), Hilman, Michigan; and *Alpena General Hospital*, Alpena, **Michigan**
- *Southern Ohio Health Services Network, Inc.* (CHC), Milford, Ohio; *Adams County Hospital*, West Union, Ohio; *Brown County Hospital*, Georgetown, Ohio; and *Highland District Hospital*, Hillsboro, **Ohio**
- *White River Rural Health Center, Inc.* (CHC), Augusta, Arkansas; *White County Medical Center*, Searcy, Arkansas; and *Baptist Health Medical Center*, Heber Springs, **Arkansas**

**RWHC Rural Health Essay Competition  
15th Annual \$1,000 Prize - April 15 Deadline**

The Hermes Monato, Jr. Prize of \$1,000 is awarded annually for the best rural health paper. It is open to all students of the University of Wisconsin. Previous award winners, judging criteria and submission information are available at [www.rwhc.com/Awards/MonatoPrize.aspx](http://www.rwhc.com/Awards/MonatoPrize.aspx).

---

## Are You Taking Full Advantage of RAC?

---

The Rural Assistance Center (RAC) is a product of the U.S. Department of Health and Human Services' Rural Initiative. RAC was established by then Secretary Tommy Thompson in December 2002 as a rural health and human services information portal. RAC helps rural communities and other rural stakeholders access the full range of available programs, funding, and research that can enable them to provide quality health and human services to rural residents. They are a clearinghouse of rural health and human services resources with information specialists providing free assistance to:

- Identify potential funding opportunities
- Locate appropriate federal or state agency contacts
- Find print and electronic documents
- Locate statistics, data sources and maps

**Invest some time at** <http://www.raconline.org/>.

Space Intentionally Left Blank For Mailing