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

Some is Not a Number; Soon is Not a Time

From the Commentary "100,000 Lives Campaign, Setting a Goal and a Deadline for Improving Health Care Quality" by Donald M. Berwick, MD, MPP, FRCP; David R. Calkins, MD, MPP; C. Joseph McCannon, BA; Andrew D. Hackbarth, BA in *JAMA*. 2006;295:324-327:

"A half decade has elapsed since the Institute of Medicine released 2 landmark reports on health care safety and quality, *To Err Is Human* and *Crossing the Quality Chasm*. Those studies helped articulate a broad agenda for quality improvement in health care, and examples of success on a small scale are numerous. However, the collective impact of improvement work has been far below the potential envisioned by the Institute of Medicine. Health care can benefit now from a new sense of urgency, with levels of discipline and pace akin to those of a political campaign."

"Political campaigns cannot afford patience. Political campaign professionals often cite the rule: 'Some is not a number; soon is not a time.' A campaign works with a firm target: 50% plus one: the number of votes needed to win—one less is not enough—and a firm deadline: election day."

"To quicken the pace of quality improvement in health care, the Institute for Healthcare Improvement (IHI) in December

2004 launched the 100,000 Lives Campaign—a national initiative with a goal of saving 100,000 lives among patients in hospitals through improvements in the safety and effectiveness of health care."

"For operational purposes in the campaign, a 'life saved' is defined as a patient successfully discharged from a hospital who, absent the changes achieved during the campaign, would not have survived. Arbitrarily, IHI set a deadline of June 14, 2006, for achieving that goal, precisely 18 months after the announcement of the campaign at the IHI's 16th Annual National Forum on Quality Improvement in Health Care. All of the nation's 5,759 hospitals have been invited to join through a simple enrollment process, explained on the IHI web site (**www.ihi.org**), and they have been requested to acknowledge publicly their involvement, regularly sharing their progress in reducing mortality."

"How can US hospitals possibly save 100,000 lives by June 14, 2006? The campaign proposes that US hospitals implement as many as possible of 6 highly feasible interventions for which efficacy is documented in the peer-reviewed literature and is reflected in standards set by relevant specialty societies and government agencies."

Deploy Rapid Response Teams—"Rapid response teams, also referred to as medical emergency teams, resemble code teams in that they are staffed by health care professionals with critical care expertise, often including a physician, a nurse, and a respi-

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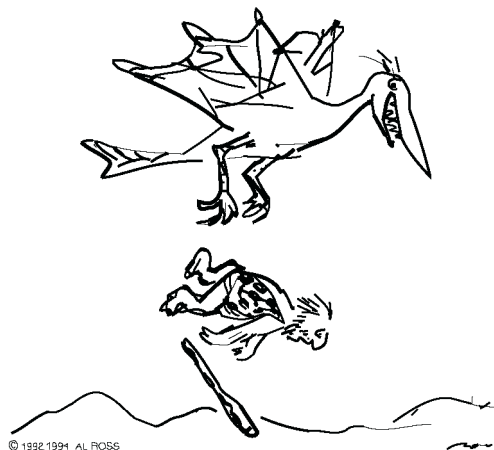
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"When the obvious becomes obvious, the time to adjust is limited."

ratory therapist. However, unlike a code team, a rapid response team is summoned before a code occurs."

"Rapid response teams can save lives among patients who would otherwise experience cardiac arrest and die in the hospital. Rapid response teams can do this either by initiating changes in care that prevent the arrest or by facilitating transfer to an intensive care unit (ICU), where fast resuscitation efforts following a cardiac arrest are more likely to be successful. A number of hospitals that have implemented rapid response teams have reported a reduction in cardiac arrests, deaths, or both, as well as a reduction in ICU and hospital length of stay among survivors of cardiac arrest."

Deliver Reliable Evidence-Based Care for Acute Myocardial Infarction—"Every year, an estimated 900,000 individuals in the United States are diagnosed with acute myocardial infarction, and approximately 350,000 of these patients die during the acute phase. The essential elements of care for acute myocardial infarction are well known and have been articulated in guidelines issued by the American College of Cardiology and the American Heart Association. The Centers for Medicare & Medicaid Services has incorporated these same elements of acute myocardial infarction care in its Hospital Quality Initiative. Key components of acute myocardial infarction care (for appropriate patients, as specified in the American College of Cardiology–American Heart Association guidelines) include early administration of aspirin, aspirin at discharge, early administration of a β-blocker, β-blocker at discharge, angiotensin-converting enzyme inhibitor or angiotensin-receptor

blockers at discharge for patients with systolic dysfunction, timely initiation of reperfusion (thrombolysis or percutaneous coronary intervention), and smoking cessation counseling."

Prevent Adverse Drug Events Through Medication Reconciliation—"The Institute of Medicine has estimated that medication errors account for 7000 deaths annually. A recent study including chart review suggests that more than half of all hospital medication errors occur at the interfaces of care, for example, when patients are transferred from the emergency department to an inpatient bed, are transferred between units within the hospital, or are in transit between hospital and home or an extended care facility. Because drug errors at transitions in care are so frequent, medication reconciliation has a role at all transitions in care. Medication reconciliation is a process by which a clinician reviews the patient's medication orders and tracks the medications actually administered before and after the transition in site of care so as to identify and correct any discrepancies between the intended regimen and the regimen actually received. Recognizing the importance of medication reconciliation to a reduction in adverse drug events among hospitalized patients, the Joint Commission on Accreditation of Healthcare Organizations included medication reconciliation in the 2005 National Patient Safety Goals for hospitals."

Prevent Central-Line Infections—"The Centers for Disease Control and Prevention has issued an evidence-based guideline that identifies many elements of care shown to reduce the risk of central intravascular catheter infection. Based on this guideline, the campaign specifies a central-line bundle: 5 components of care that appear to be particularly important in reducing the risk of central-line infection: hand hygiene, maximal barrier precautions, chlorhexidine skin antisepsis, optimal catheter site selection (the subclavian vein is the preferred site for nontunneled catheters in adults), and daily review of line necessity, with prompt removal of unnecessary lines."

Prevent Surgical Site Infections—"The Centers for Disease Control and Prevention has issued a comprehensive, evidence-based guideline for the prevention of surgical site infection. This guideline addresses preoperative care (including preparation of the patient and antimicrobial prophylaxis), intraoperative

care, postoperative incision care, and surveillance. Based on this guideline and studies addressing the role of perioperative normothermia and control of blood glucose, the following 4 care components were recommended to prevent surgical site infection: guideline-based use of prophylactic antibiotics, appropriate hair removal (avoidance of shaving), perioperative glucose control (for patients who had undergone major cardiac surgery and are being cared for in an ICU), and perioperative normothermia (for patients who had undergone colorectal surgery)."

Prevent Ventilator-Associated Pneumonia—"Evidence-based guidelines for the prevention of health care–associated pneumonia, including ventilator-associated pneumonia, have been issued by the Centers for Disease Control and Prevention, the American Thoracic Society, and the Infectious Diseases Society of America. Based on these guidelines and other evidence-based recommendations for the care of patients receiving mechanical ventilation, the campaign established the goal that all such patients should receive the ventilator bundle, a group of 4 services that have been shown to reduce the incidence of ventilator-associated pneumonia and other adverse events: elevation of the head of the bed to between 30° and 45°, daily 'sedation vacation' and daily assessment of readiness for extubation, peptic ulcer disease prophylaxis, and deep vein thrombosis prophylaxis."

Conclusion—"Threats to the success of the 100,000 Lives Campaign are many, but hospital recruitment for the campaign is not among them. As of December 14th, 2005, 12 months from initial announcement, more than 3,000 US hospitals have joined."

"The challenge goes well beyond enrollment; it is for all participating hospitals to reliably introduce the recommended interventions, engaging every stakeholder group—boards, executives, frontline clinicians, patients, and families—in changing the standard of care across the country. Although the 6 interventions are conceptually simple and feasible, implementing them can be complex, requiring cultural changes, such as

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Contemporary Issues in Rural Healthcare

The first 2006 issue of the *North Carolina Medical Journal*, a Journal of health policy analysis and debate, will focus on "Contemporary Issues in Rural Healthcare." It will be available on-line at no charge (**www.ncmedicaljournal.com**).

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empowering nurses to engage a rapid response team without reprisal and persuading physician staffs to endorse the standardization upon which reliable implementation of these interventions will depend."

"If, by June 14, 2006, the campaign falls short of 100,000 lives saved, a celebration may nevertheless be in order. In the simple act of enrolling, more than half of US hospitals have publicly stated their intention to tackle a goal that is bolder and broader and with a clearer and more urgently defined target date than any prior national aim in health care. Whether that initial commitment will yield, in the end, 100,000 'lives saved,' or 50,000, or 10,000 is yet to be discovered, but the first wave of interest is encouraging."

Health Information Technology Conundrum

From a white paper "Donating Health Information Technology to Physicians: CMS/OIG Regulations Highlight a Key Challenge to Realizing an Electronic Health Record for all Americans" by McDermott Will & Emery; the complete paper is available at (**www.mwe.com/info/news/wp1105a.pdf**).

"In his January 20, 2004, State of the Union Address, President George W. Bush announced his plan to ensure that most Americans have electronic health records within 10 years: 'By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.' The President's Health Information Technology (HIT) Plan will address long-standing problems of preventable errors, uneven quality and rising costs in the nation's health care system. The President's plan includes adopting health information standards, increasing funding for health information technology demonstration projects, using the federal government's clout as one of the largest purchasers of health care in the world to create incentives for health care providers to adopt health information technology, and creating a subcabinet level position to provide the national leadership and coordination to achieve the President's goals. HIT includes electronic medical records, computerized prescribing and ordering of diagnostic tests, clinical decision support tools, and the technology necessary to assure the secure exchange of electronic health information."

HIPAA and E-Prescribing Standards—"Prior to the President's initiative, the U.S. Congress and federal agencies had helped create a platform for expanding adoption of HIT through the so-called HIPAA legislation and regulations that mandate common transaction and code sets and standards for health information security and privacy. In addition, as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Congress directed the Secretary of the Department of Health and Human Services (the Secretary) to adopt standards for electronic prescribing of drugs covered by the new Voluntary Prescription Drug Benefit Plan, also known as Medicare Part D, to improve patient safety, quality of care and efficiency in the delivery of care (e-prescribing). Sponsors of prescription drug plans (Part D sponsors) are required to support and comply with e-prescribing standards established by the Secretary. Health care professionals are not required to write prescriptions electronically; however, those who engage in e-prescribing are required to comply with the Secretary's recently published initial e-prescribing standards (the so-called Foundation Standards). The Secretary's foundation standards are in addition to existing HIPAA rules governing the creation, storage and exchange of personal health information."

The Physician Problem—"Notwithstanding the fact that the federal government has yet to promulgate standards for electronic health records (EHR) technology, HIT vendors are continually developing, upgrading and marketing HIT to public and private health plans, health systems, hospitals and large physician practices. However, the cost of adopting HIT is substantial, and public and private grants will only reach a relatively small number of providers. Although a number of voluntary regional health information organizations have been formed and a few public/private initiatives started, a number of hospitals, health systems and health plans have undertaken HIT initiatives aimed at solo and small- to medium-sized physician group practices. These practices compose the largest segment of the medical profession and are the least likely candidates to make the necessary capital outlay to adopt HIT given that most are already struggling to slow the decline in their professional incomes."

"Because physicians are the lynchpin of any meaningful development of e-prescribing and EHR systems in this country, and, generally, they will not pay for the technology, there will not be an EHR for most Americans by 2014, and the improvements in patient safety, quality of care and efficiencies the President and Secretary hail as important public policy objectives will simply not be achieved, unless Part D sponsors and hospitals can fund the adoption of HIT by physicians and other referral sources without violating the federal physician self-referral law (the Stark Law) and the federal health care program anti-kickback statute (the AKS)."

Conclusion—"Although the Secretary and the agencies have clearly recognized the chilling effect the AKS and the Stark Law is likely to have on adoption of HIT by physicians, who are the heart of the health care delivery system in the United States, the proposed exceptions are unlikely to foster the kind of widespread adoption necessary to make significant strides in the early development of an EHR for every American. Consequently, the question is whether the agencies, under the limitations of their delegated rulemaking power, are capable of creating exceptions to the AKS and the Stark Law broad enough to fulfill the administration's policy objectives. Specifically:

• Can the agencies get comfortable with physicians using donated HIT, in part, for personal, business and financial purposes not directly related to the clinical treatment of patients?

• Can the agencies get comfortable with exceptions that do not have any cap on the dollar value of the donated technology as long as the physicians must pay any incremental cost attributable to personal, business or financial uses?

• Can the agencies, prior to developing and adopting EHR technology certification criteria, get comfortable with donors drawing commercially reasonable distinctions among physicians that arguably *indirectly* take into account the volume or value of the business generated between the donor and the recipient, *e.g.*, a hospital conditioning receipt of HIT

on historical utilization of the hospital, or a Part D sponsor conditioning HIT donations on the volume of the practice's prescriptions?"

"If the answer to any of these questions is no, and Congress does not intervene to do what the agencies cannot or will not do, then the wide-spread adoption of HIT by physician practices in the near future, which is already a daunting task with an uncertain outcome, will be driven far more by market forces than any health information policy initiatives of this or any other administration."

"As for congressional intervention, it would appear the agencies' concerns regarding fraud and abuse, concerns the agencies will no doubt convey to Congress, could be substantially addressed through interoperability. Donations of interoperable technology to physicians could be encouraged without protecting donations that are, explicitly or implicitly, conditioned upon referrals to the donor or that directly take into account the volume or value of the recipient's referrals to the donor. However, even if Congress was convinced of the merit of this strategy for addressing fraud and abuse concerns, the strategy involves delaying relief from the AKS and the Stark Law until a consensus is reached on interoperability, which could take years."

"If the goal is an interoperable EHR for every American, perhaps such a delay would ultimately improve the chances of achieving the goal by preventing the proliferation of entrenched, proprietary EHR systems. If the goal is to house patient information within an EHR as soon as possible and to achieve interoperability over time, then delay of any kind is unacceptable, and the government should favor early and widespread adoption of proprietary HIT by physicians over fraud and abuse prevention. This is a critical near-term public policy choice that Congress and the administration have to make in consultation with the public and private stakeholders. If the proposed rules are any indication, it is a choice the agencies are not capable of making."

Not About Change but Organizational Agility

From "Quick Change" by Chris Musselwhite, Discovery Learning, Inc., President & CEO, in *American Executive*, 12/05; the complete article may be read at (**www.redcoatpublishing.com/features/f_12_05_Management.asp**).

"Why do so many organizational change efforts come up short? Between all the smart consultants, the change mongers, and the volumes that have been written about organizational change, you'd think we could readily answer this question. One place to look for the answer is in the definition of change: 'To make radically different; to give a different position or direction.'"

"Compare that with the definition of agility: 'Marked by ready ability to move with quick easy grace; mentally quick and resourceful.' Often, when executives ask for change, they are actually hoping for agility."

"Agility allows us to anticipate, to make quick surgical adjustments and be more proactive in an uncertain and changing business environment. In fact, a lack of agility may be the reason organizations feel the need for the large-scale change projects that typically prove disappointing."

"The first thing to recognize is that agility cannot reside just at one level of your organizational chart. Each individual, team, and business unit needs to be comfortable with the intellectual and emotional agility

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"I could get used to this new management style."

they'll need to respond to changing market demands and opportunities."

"An organizational culture that embraces agility is one that's comfortable with paradox. With a paradox, it's never about either/or, it's always about and/both. This is a difficult concept for some managers. You'll need managers and consequently an organizational culture that can simultaneously grasp, appreciate, and live with many paradoxes."

"In agile organizations, change is not a goal or event but an aspect of organizational culture that anticipates and facilitates adaptability. Such organizations are home to agile leaders and employees who work together toward a common purpose—to address new challenges and opportunities as they arise, with clarity of purpose and intent."

Chris Musselwhite is the author of Dangerous Opportunity: Making Change Work and the CEO and founder of Discovery Learning, Inc., a leadership development products and consulting company (www.discoverylearning.com). He can be reached at cmusselwhite@discoverylearning.com.

Improving Health One Community at a Time

Communities have an interest in improving their own health and lowering costs. All stakeholders, including government agencies, employers, schools and health providers can benefit from the implementation of techniques listed in the "Guide to Community Preventive Services" (www.thecommunityguide.org/) developed by the Centers for Disease Control and Prevention (CDC). The Guide is of particular interest to state efforts such as the Strong Rural Communities Initiative sponsored by Wisconsin's Rural Health Development Council. Below is a summary from "New Guide Highlights Most Effective Prevention Practices" by Kim Krisberg in *Nation's Health*, 1/05:

"Leading health professionals came together to launch the 'Guide to Community Preventive Services' and called on public health workers to use it as a primary guide in their work to improve Americans' health. Touted as a 'one-stop' resource for improving

community health, reflected in the guide are almost 10 years of systematic reviews of thousands of scientific studies, culminating in conclusions on 119 public health interventions and 54 specific recommendations on how to address pressing health issues. The guide was developed under the leadership of the independent, non-federal Task Force on Community Preventive Services and addresses nine specific health issues: physical inactivity, cancer, diabetes, vaccine-preventable diseases, tobacco, interventions in education and housing sectors, motor vehicle injury, oral health and violence. Although the task force has addressed each topic before via scientific journals and online publications, the new guide presents the first time all of the information will be combined into one, comprehensive document."

" 'Given what we know from the community guide, we could improve Americans' health significantly and easily by adopting these simple measures in our schools, work places and communities,' said Jonathan Fielding, MD, MPH, MBA, chair of the task force."

"Under each of the main health topics, the guide focuses on areas that if addressed could lead to better health outcomes. For example, the chapter on oral health addresses dental caries, oral cancers and sports-related injuries, while the chapter on motor vehicle occupant injury looks at issues such as child safety seats and alcohol-impaired driving. In the chapter about tobacco, the guide provides readers with evidence on strategies used to increase cessation and strategies to reduce youth tobacco use as well as on programs that aim to lower people's exposure to environmental tobacco smoke."

On Becoming a Radical Moderate

From the book jacket of *Deepening the American Dream: Reflections on the Inner Life and Spirit of Democracy* by Mark Nepo (Editor):

"In the 1830s the French writer Alexis de Tocqueville came to the United States to chronicle the character of this new nation. In Democracy in America he defined and described the 'habits of the heart' that vitalized the experiment called America. De Tocqueville found

many contradictory qualities in those early Americans and wrote about them with insight. The questions of who we are as Americans and how we are living out the dreams and hopes of our founders are still very much alive for us today."

"Deepening the American Dream offers a collection of reflections on the spiritual meaning of being American in today's world from some of our most respected thinkers: Gerald May, Jacob Needleman, Elaine Pagels, Robert Inchausti, Parker Palmer, and others. Deepening the American Dream explores the inner life of democracy, the way citizens are formed, and considers the spiritual aspects of the American dream: life, liberty, and the pursuit of happiness. With original essays from distinguished writers and thinkers, this important work examines the American dream and gives us a deeper understanding of who we are now and what our dreams and aspirations are today."

"Of the many sources of American resiliency, the deepest is our ability to seek, listen, and synthesize the many into the one, the many into what will serve the common good. Despite the differences and perceived animosity between our major political parties, citizens are hungry for honest conversations in which we can clarify who we are as a nation and as a people. Deepening the American Dream offers all Americans thoughtful consideration of the spiritual aspects of our common dream."

(The following is from a review by David Dark in *The Christian Century*, 11/15/05*)* "Parker Palmer concludes the collection with 'The Politics of the Brokenhearted,' a hard look at the way Americans have become adversarial listeners and speakers on both sides of any and every issue, declaring war on anyone who can be made to represent the objects of our fear and hurt. He talks about the way self-described religious liberals often bathe in their anger toward those broadly perceived as fundamentalist. With liberal Christianity on the decline, 'we brokenhearted liberals now have a

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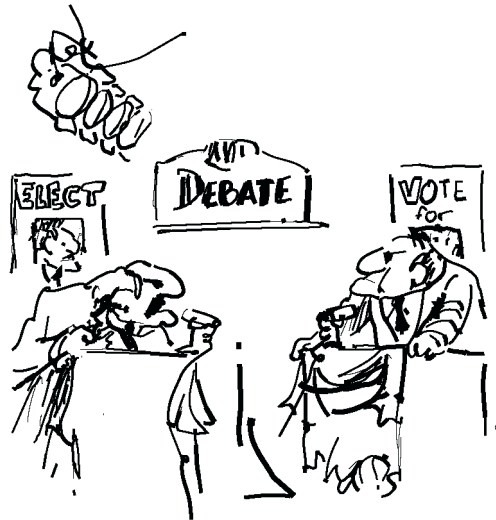
"I could agree with your position, if I wasn't raising money for reelection."

chance to identify with the experience of brokenheartedness that still characterizes critical segments of the fundamentalist community.' "

"This kind of lonely hearts club strikes me as the kind of religious (spiritual) expression that can be seen, touched and talked about—as the sort of thing Whitman called 'cosmic democracy' and that Melville perhaps had in mind when he named humanity a 'multiple, pilgrim species.' Palmer cites the Sufi master Hazrat Inayat Khan, who said, 'God breaks the heart again and again and again until it stays open.' "

"In keeping with this sensibility, *Deepening the American Dream* communicates a determined magnanimous solidarity to a fragmented age of confusion and escalating resentments. I'd hate to see it sequestered in the spirituality section of a library or bookstore as much as I hope it won't be dismissed as another salvo in the culture wars. But of course the collection is political (multipartisan sense), a gesture of peace and goodwill that summons us to come together, confessing our heretofore unacknowledged animosities and willful mischaracterizations of people's positions. It's a powerfully uplifting book that shines light in the direction of incarnate hope. That rare happening of people actually talking to each other."

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Starting March 10th, Rural Health Careers in Wisconsin will bring rural healthcare employers and profes-

sionals together via the Internet. The service is FREE, up-to-date and comprehensive. Visit **www.rhcw.org** to find the job you want in the location of your choice!!

How do I access the web site?
Start by entering **www.rhcw.org** using your Internet browser—this will take you to the Rural Health Careers in Wisconsin web site. To search available openings, click on *"Search Job Postings"* and select the job categories and/or geographic locations that are of interest to you. Once there, you will find search options for…

- Job postings by category, subcategory, region
- Individual hospitals/clinics, including links to on-line applications (when available)
- Specific community information with map links
- Other online resources for career information, loan repayment programs, tuition assistance, and internships/ clinical opportunities

- Opportunity for job seekers to post resumes online
- Auto-notification of application/resume receipt
- Interactive map of Wisconsin
- Links to hospital/clinic web sites, maps, chambers of commerce, etc.

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