

Review & Commentary on Health Policy Issues for a Rural Perspective – August 1<sup>st</sup>, 2010

## Health Care Reform & Our Political System?

Abstracted from “Presidents and Health Reform: From Franklin D. Roosevelt To Barack Obama” by James Morone in *Health Affairs*, 6/10:

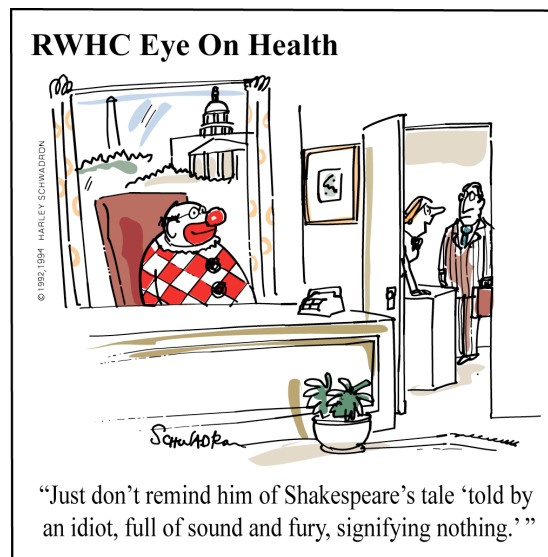
“Despite the historic achievement, great hurdles lie ahead. The implementation of this complicated legislation introduces almost as many challenges as passing it did—and will be just as crucial to the program’s success. However, implementation introduces a very different kind of politics largely outside the media spotlight, without the dramatic votes or tight schedules.”

**“From Politics to Pragmatism—**Getting the reform through Congress required one compromise after another: There is no public option or Medicare buy-in; there are attenuated cost controls and more limited subsidies for buying private insurance. Even after all of those compromises, the plan passed without a single Republican vote. For the Democrats, the perils ahead are obvious. If the legislation proves unpopular or unworkable, they will be entirely responsible.”

“Moreover, with this reform, the government owns the problem of health care for most of the population. Requiring all individuals to buy coverage will turn each spike in private insurance premiums into a public policy problem. As a result, the success of the program will rest, in no small measure, on effective responses to future problems.”

“When a man is wrapped up in himself, he makes a pretty small package.” John Ruskin  
RWHC Eye On Health, 7/27/10

“For Republicans, the political calculations—and the perils—are even more dramatic. Only ten Republicans in the House supported Medicare, only one Social Security. But they voted ‘nay’ on complicated parliamentary maneuvers and switched sides once passage was inevitable. This time, Republican opposition remained unambiguous and unwavering. As the Obama reform moves into implementation, Republicans face a conundrum. Implementation is about negotiating details more than simple up-or-down votes. At what point does Republican resistance look like stubborn obstruction? And what are the consequences if the program takes effect despite their opposition and proves popular (as most health programs have done)?”



“Republican majorities always have to prove that they can address the nation’s health care needs and be good stewards of popular programs. As a result, they have often gone further to prove their health care bona fides. They have thought creatively about health reform: The Nixon administration’s national health insurance proposal is a clear forerunner of the Clinton plan; the Republican counter to the Clinton plan, sponsored by Republican Senators Bob Dole (R-KS) and John Chafee (R-RI), is now known as Obamacare. Moreover, the largest extensions of Medicare came from our most conservative presidents, Ronald Reagan (catastrophic coverage) and George W. Bush (prescription drugs). If the fledgling Obama reform survives, Republicans may very well feel the pressure to defend, protect, and even expand it.”

“**Testing the Political System**—On a deeper level, the implementation of health reform will offer another test of our political system itself. Democrats and Republicans have very different health care visions. The congressional process is designed for precisely that kind of clash between philosophies; the implementation process, however, ought to be geared toward efficiently implementing whatever Congress decides.”

“Although some politics is inevitable, if each party tries to subvert the programs passed by the other party, Americans will have good reason to worry that the troubles of the ‘broken branch’ have metastasized into a dysfunctional political system.”

---

## An Alternative View on Primary Care Quality

---

The following editorial “The worst doctor in the worst clinic” is by John J. Frey, III, MD, in the current issue of *Wisconsin Medical Journal*:

“A double distortion lies at the heart of paying for primary care: Clinicians are paid for throughput, charges and piecework—sometimes called efficiency—and are increasingly being ‘paid’ for quality. The piecework creates a process—high volume, high cost, and high charges—that is antithetical to the proper role of primary care in the process of care. Primary care

**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. *This newsletter often presents a variety of opinions that may or may not be supported by the editor or RWHC.*

Tim Size, RWHC Executive Director & EOH Editor  
880 Independence Lane, Sauk City, WI 53583

Website: [www.rwhc.com](http://www.rwhc.com) Twitter: <http://twitter.com/RWHC>  
Blogs: [www.ruraladvocate.org/](http://www.ruraladvocate.org/) [www.worh.org/hit/](http://www.worh.org/hit/)

Email [office@rwhc.com](mailto:office@rwhc.com) with *subscribe* on the Subject line for a free e-subscription.

providers need to spend adequate time and effort on the management of multiple complex problems of individual patients using clinical judgment that is both cost effective and evidence based. They also should target higher risk groups within a practice population that need more attention and creative strategies for care. Doing less pays less under the current system, even if less, in many cases, is better for patients. The term ‘production’ used by health systems to pay primary care doctors is a wonderful metaphor for what medicine feels like. Charlie Chaplin in the factory scene in *Modern Times* captures the feeling better than anyone could describe it.”

“The term quality is the second distortion—at least how it is used in US health care as determined by insurance companies and the National Committee for Health Care Quality (NCQA), the self appointed guardian of quality. The current term used is ‘pay-for-performance’ and conjures images of dogs being rewarded with treats for jumping through hoops in the circus. No one, of course, argues against quality but a lot of clinicians argue about what quality means and how it should be measured. Linking quality measures to payment raises a whole raft of issues for primary care when those payments are also linked to reimbursement for billable services and don’t take a practice population into consideration.”

“A study of pay for performance comparing physician attitudes between family doctors in California and GPs in Britain showed that the British GPs felt better about the process and its subsequent effect on their income compared to the California family doctors who felt overburdened and under resourced. This should come as no surprise. In England, GPs have a base average salary of one hundred thousand pounds (roughly \$180,000) upon which pays for quality can be added but not subtracted. The results are a much better achievement of quality improvement and an increase in compensation of the British GPs compared the US doctors who, depending on meeting quality grades, put up to 1/3 of their basic income at risk. In addition, British GPs use quality measures derived from their own practices while California physicians were judged by external criteria, mostly from the NCQA.”

“I have been in practice at a residency teaching clinic for almost 17 years, a clinic whose popula-

tion, in contrast to other practices in our health system, is ethnically diverse with disproportionately lower incomes, with a high percentage of Medicaid, permanently disabled and uninsured patients. Every month I get an individual report on how patients of mine meet NCQA measures of ‘control’ of diabetes and most months since this started, I have ranked dead last and our clinic ranks last of all the clinics in the system. So, by externally derived quality measures, after 40 years of being a doctor, at least for diabetes, I have been deemed the worst doctor in the worst clinic. As I go through my list, I recognize names of patients who are uninsured or, because of high deductibles or co-pays, are effectively uninsured who have enormous economic and social burdens, who struggle with paying to come to our clinic, spreading their medications over longer periods of time than they should because they need to buy food and pay rent. My clinic colleagues and I have looked at our diabetes patients and found that, despite these challenges, we are improving their HgbA1c levels but not making the magic ‘7.0 or less’ benchmark. If we were British GPs, we would be rewarded for progress but because we are in the US, we are punished for not meeting externally driven ‘standards’. The quality system in the US is pass-fail, not improvement.”

“Higher risk practices, just like higher risk school systems, need more and different resources than those at lower risk. Research repeatedly supports the view that more resources improve care in higher need primary care. In the British NHS, community nurses, paid by the NHS, work with each practice to broaden care by doing home visits to patients who are missing care and do care management in the community, not simply in the office. Higher need communities get more nurses than those with less need. In our practice, we get supported for office based staff at the same rate or less than practices with less demanding populations. But the current production driven reward system assures that practices with patients who have socioeconomic as well as medically complex problems will have less to invest in care. Disparities in health outcomes in society often mirror the disparities in practice

support for clinics trying to care for socioeconomically burdened communities, a concept first identified almost 40 years ago which stated that ‘the availability of good medical care tends to vary inversely with the need for it in the population served.’ ”

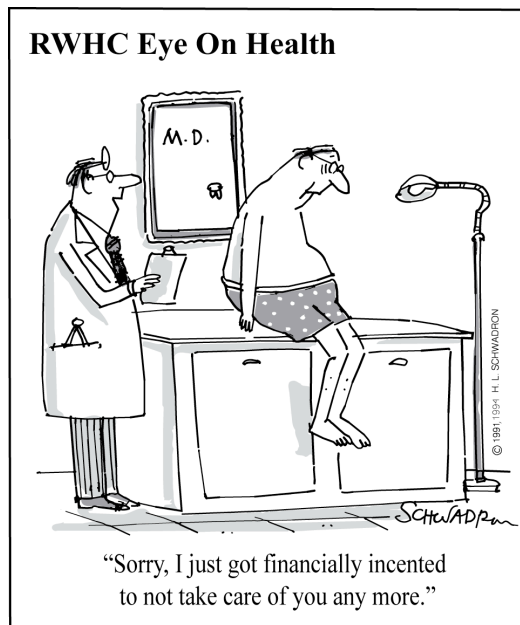
“I realize I am not the worst doctor and I know my clinic is not the worst practice—we have been providing consistently high quality care for over 35 years to our community. We are all—whether an ‘A’ doctor or ‘F’ doctor—locked into narrow definitions of quality which are often poorly tested. For example, a recent study demonstrated the risk of increased mortality for type 2 diabetic patients whose HgbA1C is driven BELOW the NCQA goal of ‘less than 7.0.’ This study was interrupted before it was completed because of the danger to patients who were treated aggressively. But

the ‘standards’ for the diabetes report card hasn’t changed. Even if loosening the standards of quality might actually save patients lives’, it doesn’t seem to matter. Pushing primary care clinicians to put our patients at risk to achieve increased pay-for-performance goals presents an intolerable conflict of interest.”

“Any attempt to improve the morale and quality in primary care requires changing not only how much primary care providers are paid but more importantly how they are paid. Large groups or collaboratives and insurance

companies can find ways to experiment in primary care by paying for populations, which would let the practices concentrate more on innovation than on throughput. An experiment at Group Health in Seattle showed that investment in primary care that is not production driven can lower costs, free up more time for patients and increases both provider and patient satisfaction.”

“Why not try giving primary care doctors a dependable base income and reward improvement? Ask them to improve the health of their overall practice population rather than meet arbitrary and evidence-poor ‘benchmarks.’ Push collaboration with many different health professionals who can divide both the work and



the reward for doing better. Discovering new ways of delivering care would not pit the ‘high producers’ against the rest, and concentrate on health not billings. It would be a better world for doctors and patients alike. It is not too late to try.”

---

## Rural Hospitals Lead on Patient Assessment

---

The Upper Midwest Rural Health Research Center (and its predecessor at the University of Minnesota), have a long and distinguished record of helping the rural health community better understand some of our most challenging issues. They are also the rural research center with the largest portfolio related to quality measurement. Key findings from their June report, “Patient Assessments and Quality of Care in Rural Hospitals” by Michelle Casey and Gestur Davidson are particularly encouraging:

“Hospitals in rural areas have significantly higher ratings on patients’ assessments of care, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, than those located in urban areas. Within rural areas, hospitals in less densely populated rural areas (non-core) score significantly higher than those in more densely populated (micropolitan) areas.”

“After controlling for hospital organizational characteristics, differences by rurality remain significant for all the HCAHPS measures except the patient recommendation of hospital measure.”

**“Hospital for-profit status and inpatient volume are significantly and negatively related to HCAHPS scores.** Nursing and pharmacist staffing variables have smaller but significant positive relationships with several HCAHPS measures.”

“The HCAHPS overall hospital rating and willingness to recommend scores are significantly related to process of care quality measures for heart failure and pneumonia and a hospital-wide process of care composite measure. However, the statistical relationships between these HCAHPS scores and the process measures are not as strong as the statistical relationships between the HCAHPS scores and certain hospi-

tal organizational characteristics such as size and for-profit ownership.”

“Differences in the overall performance of smaller rural hospitals relative to larger urban hospitals on the HCAHPS measures and the process of care measures suggest that the two sets of measures are measuring different aspects of quality.”

---

## National Insurers Limit Choice of Providers

---

From “Insurers Push Plans Limiting Patient Choice of Doctor” by Reed Abelson in *The New York Times*, 7/17/10:

“As the Obama administration begins to enact the new national health care law, the country’s biggest insurers are promoting affordable plans with reduced premiums that require participants to use a narrower selection of doctors or hospitals.”

“The plans are likely to appeal especially to small businesses that already provide insurance to their employees, but are concerned about the ever-spiraling cost of coverage.”

“The tradeoff, they say, is that more Americans will be asked to pay higher prices for the privilege of choosing or keeping their own doctors if they are outside the new networks. Companies may be able to reduce their premiums by as much as 15 percent, the insurers say, by offering the more limited plans.”

“ ‘What we’re seeing is a definite uptick in interest because, quite frankly, affordability is the most pressing agenda item,’ said Dr. Sam Ho, the chief medical officer for UnitedHealth’s health-care plans.”

“Many insurers also expect the plans to be popular with individuals and small businesses who will purchase coverage in the insurance exchanges, or marketplaces that are mandated under the new health care law and scheduled to take effect in 2014.”

“The last time health insurers and employers sought to sharply limit patients’ choice was back in the early 1990s, when insurers tried to reinvent themselves by



embracing managed care. Instead of just paying doctor and hospital bills, insurers also assumed a greater role in their customers' medical care by restricting what specialists they could see or which hospitals they could go to."

" 'Back in the H.M.O. days, it was tight networks, and it did save money,' said Ken Goulet, an executive vice president at WellPoint, one of the nation's largest private health insurers, which is experimenting with re-introducing the idea in California. The concept was largely abandoned after the consumer backlash persuaded both employers and health plans that Americans were simply not willing to sacrifice choice. Officials like Mr. Obama and Hillary Rodham Clinton learned to utter the word 'choice' at every turn as advocates of overhauling the system."

"But choice—or at least choice that will not cost you—is likely to be increasingly scarce as health insurers and employers scramble to find ways of keeping premiums from becoming unaffordable. Aetna, Cigna, the UnitedHealth Group and WellPoint are all trying out plans with limited networks."

"In New York, Aetna offers a narrow-network plan that has about half the doctors and two-thirds of the hospitals the insurer typically offers. People enrolled in this plan are covered only if they go to a doctor or hospital within the network, but insurers are also experimenting with plans that allow a patient to see someone outside the network but pay much more than they would in a traditional plan offering out-of-network benefits."

"The insurers are betting these plans will have widespread appeal in the insurance exchanges as individuals gravitate toward the least expensive options. 'We think it's going to grow to be quite a hit over the next few years,' said Mr. Goulet of WellPoint."

"The new health care law offers some protection against plans offering overly restrictive networks, said

Nancy-Ann DeParle, head of the office of health reform for the White House. Any plan sold in the exchanges will have to meet standards developed to make sure patients have enough choice of doctors and hospitals, she said."

"Ms. DeParle said the goal of health reform was to make sure people retained a choice of doctors and

hospitals, but also to create an environment where insurers would offer coverage that was both high quality and affordable. 'What the Congress and the president tried to accomplish through reform is to transform the marketplace by building on the existing system,' she said."

"UnitedHealth is experimenting with a more limited plan in California and Chicago and plans to expand to four or five other markets next year. Patients are al-

lowed to see a doctor who is not in the network the insurer established, but they pay much higher out-of-pocket costs than they would in a traditional plan offering out-of-network benefits."

"UnitedHealth is also starting a new plan in the San Diego area, which was developed for a collection of school districts, representing some 80,000 people. The plan creates tiers of doctors, and employees who use physicians deemed to offer high-quality care at low price will pay the least for their medical care."

"One way insurers say they hope to prevent another consumer backlash is by emphasizing that they are not choosing doctors on price alone. The insurers say they look to see how quickly a doctor's patients recover from surgery, for example. But how much the insurers emphasize quality remains to be seen."

"But many insurers say they are still figuring out how to persuade people to choose these plans rather than force them to enroll. Mark T. Bertolini, Aetna's presi-

dent says 'we have to create the same kind of model without the 'Mother, may I.' What we want is the 'Mother, should I.' "

### RWHC Eye On Health



### RWHC Social Networking:

The Rural Health Advocate: [www.ruraladvocate.org/](http://www.ruraladvocate.org/)

Rural Health IT: [www.worh.org/hit/](http://www.worh.org/hit/)

---

## Children First & Rural Food Systems

---

The 2010 RWHC Monato Rural Health Essay \$2,000 Prize is awarded to Heidi Busse, a Master of Public Health candidate at the University of Wisconsin School of Medicine & Public Health.

Heidi graduated from Clintonville High School (about 40 miles west of Green Bay, Wisconsin). She has been in the Peace Corps and worked for Heifer International, the Land Stewardship Project, and the WI Department of Agriculture. After graduation, she hopes to apply her public health skills and knowledge to work with rural communities to improve health and nutrition through strengthened local food systems.

The following is from her essay “Children First: Using Community Food Systems to Improve Early Childhood Nutrition in Rural Wisconsin”:

“I was raised on a dairy farm in northern Wisconsin. We had a small herd of Holstein cows, whose milk was picked up daily and trucked to the local cheese cooperative. There our milk was mixed with our neighbors’ milk, transformed into curds which were stuffed into molds, and shaped into commodity cheeses like Colby Longhorn, Brick, Muenster and Cheddar. From the cheese factory, the products went off to market, trucked down to Chicago or out East to New York without any trace of the hands that formed the cheese wheels or milked the cows. These cheeses told a story of commerce and progress, using economic exchange as a way to adequately feed a country that survived lean Depression years.”

“They also told a story of severed relationships, of farmers separated from controlling their milk prices; cheesemakers divorced from making cheeses that reflected the seasonality and flavor profiles of the milk; and consumers torn from local farmers and regional foods. These cheeses told a story of broken landscapes, whose livelihoods were driven by outside interests and markets, and the political and cultural shifts that led to this.”

“But I remember a different story of growing up in rural Wisconsin. I remember each day being shaped by the chores that needed to be done, our family’s

routine and decisions molded by the needs of the farm. I remember eating the foods of our labors and tasting the seasons—wild onions in the spring milk when the cows grazed the back forty pasture; green beans, peas and tomatoes that we would snatch from the bucket when harvesting the garden; and corn on the cob that somehow held the flavor of sunshine and July heat even when pulled out of the freezer in January. The farm formed us and gave us a pattern of labor and consumption tied to the place, and connected us with a larger community that taught us shared values. These values kept our farms, families and communities in balance until we left. Until we and the majority of our neighbors left our farms, dramatically changing the shape and structure of our rural town.”

“The agricultural changes and loss of family farms that my small town experienced happened in communities across rural Wisconsin and America throughout the mid to late 20<sup>th</sup> century. What I did not realize growing up was that as the health of rural Wisconsin landscapes and *economies* declined, so too did the health of rural Wisconsin *bodies*. I first learned of the larger global and economic forces that eliminated thousands of family farms a decade after we moved. And it took me yet another decade to see that, concurrent with the decline of our rural economy, the health outcomes of people in my small town were declining rapidly. Heart disease, cancer, obesity, diabetes and mental health issues are all on the rise in rural communities across the state, nation and world. Which leads me to wonder, what is the relationship between the health of a rural economy and the health of its people? By improving our rural economies and creating healthy environments, can we start to rebuild individual health and improve community wellness?”

“Growing up on a farm, I experienced how the health of the landscape and people **are** intimately intertwined. Unfortunately, our current ways of producing food destroy the health of our bodies, communities and natural resources. The industrial agricultural system has brought us market efficiencies, improved production systems, better food sanitation processes and reduced hunger and malnutrition. However, it has created new problems for my and future generations to address: polluted soils, water and air due to pesticides and fertilizers; excessive reliance on fossil fuels for production; working conditions that are neither

just nor fair to farmworkers; economic benefits that reward wealthy corporations and destroy local economies; and a health care crisis with the global rise in obesity, diabetes and other chronic diseases. If we could create a more resilient, balanced food system, would it not also ease some of the pressures off of our ailing health care system?"

"One way to create community health is to rebuild rural communities' local food infrastructure to emphasize local, sustainable and healthy foods. A community food system is 'a collaborative network that integrates sustainable food production, processing, distribution, consumption and waste management in order to enhance the environmental, economic and social health of a particular place.' Community food systems increase participation by farmers, consumers and communities, and strengthen these relationships to create locally-based, self-reliant food economies that improve social, economic and environmental health. Community food systems require interdisciplinary teams who collaborate to create plans that integrate the health of rural people, economies and environments."

"Currently, only 7% of Americans consume the recommended level of fruits and vegetables on a daily basis, and this contributes to many chronic health concerns. But what would happen if the other 93% of Americans suddenly woke up and decided to eat as the American Dietetic Association recommends, meeting the recommended daily allowance of fruits and vegetables? Dr. Mike Hamm, C.S. Mott Chair of Sustainable Food Systems at Michigan State University, states that the United States would not have enough whole, unprocessed fruits and vegetables to supply this need. To meet such a demand, the U.S. would need to turn 13 million acres of land into vegetable production—and find the farmers who would manage it, local markets that would transport, process and distribute the produce, and grocers who could sell it."

"This story illustrates why community food systems are not just an agricultural issue, but a public health issue. For community food systems to improve *public health*, they need to be designed in ways to mitigate

socioeconomic disparities and ensure healthy food access, availability and affordability to all. One important way to ensure good community health is to establish positive eating habits early in children, and to provide parents and providers with appropriate nutrition education, resources to make healthy decisions, and access to healthy foods."

*Read how a community food systems approach is "vital to improve the health of rural lands, economies, and people" by reading the complete essay at <http://www.rwhc.com/> under the "Awards" tab.*

---

## Communication: Advocacy vs Inquiry

---

From the RWHC newsletter *Leadership Insights* by Jo Anne Preston, RWHC Workforce & Organizational Development Manager, 6/10:

### How to Communicate Better?

#### **You tend more towards advocacy in style?**

Intentionally try out the inquiry examples in your conversations with employees. You might be rewarded with ideas you hadn't considered.

#### **You're more comfortable using an inquiry approach?**

Then try on the advocacy examples with others. You may find employees better understand what you expect.

"You can improve your communication (and most of us want or need to) by first identifying your own communication wiring. One lens to look through is whether you use more *Advocacy or Inquiry*. In a nutshell:

**A-Advocacy** is communicating to state your position. Some advocacy examples:

- I think it's important for you to try (x).
- Here is why this matters:
- This is what I need to see:
- I will do (x) for you:
- I believe (x) because:"

**I-Inquiry** is communicating in a manner that nudges others to reveal their thinking. Some inquiry examples:

- Can you walk me through how you came to your decision?
- What's the best possible outcome you can imagine in this situation?
- How can we make this happen?
- How can I help?
- How do you see your role in this project?"

“We all use a mix of **A & I** but most have a comfort zone more in one than the other. If you aren’t sure how you come across, seek some feedback from someone you work with regularly. Ask them to read the examples above and identify which way you are *more likely* to come across in your communications.”



## RURAL HEALTH CAREERS WISCONSIN

“It’s easy to see how both styles have their strengths. Strong advocates are more likely to let you know where they stand and are more definitive, removing uncertainty. Those skilled in inquiry elicit more ideas than they can come up with alone and leave people feeling important for being asked.”

“Like any strength though, either approach can create problems when you over-rely on it. Too much advocacy may make others feel like their ideas don’t matter or that it is not okay to disagree or discuss. Too much inquiry can feel like an interrogation, or lead to endless options never landing on a decision.”

“Clear communication is achieved through a **balance** of advocacy and inquiry...fancy words for *reveal your thinking* and *probe thoughtfully*, with a good dose of “***listen well***” added in.”

### “Tips for the A’s:

- After advocating your point, ask for others to challenge your thinking and keep an open mind-the best results come from lively dialogue.
- If it feels like using inquiry slows things down, make using inquiry a ‘task;’ it’s worth a few extra minutes to get the other person’s best thinking.”

### “Tips for the I’s:

- Remember, stating your point clearly doesn’t mean you are being ‘bossy.’
- Advocating doesn’t close doors to additional dialogue. Others want to know what you think too.”

*Information on the 2009-10 RWHC Leadership Education Series as well as past issues of “Leadership Insight” are available at <<http://www.rwhc.com>>. Jo Preston can be contacted at [JPreston@rwhc.com](mailto:JPreston@rwhc.com) or 608-644-3261.*

Space Intentionally Left Blank For Mailing