

Review & Commentary on Health Policy Issues for a Rural Perspective – April 2<sup>nd</sup>, 2008

## Medicare Dis-Advantage

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative, first published in the Wisconsin Hospital Association's Valued Voice, 3/7/08:

The Government Accountability Office, the nonpartisan investigative arm of Congress, reports that in the next four years, Medicare Advantage (MA) insurance plans will be paid \$54 billion more than what would have been paid under traditional Medicare. These for-profit plans contract with Medicare to provide all Medicare benefits. MA Plans are HMOs, PPOs, or Private Fee-for-Service Plans. Medicare services are covered through the plans, and are not paid for under the original Medicare.

While many MA enrollee out-of-pocket costs are projected to be lower, others will be higher and in general there will be few extra enrollee benefits. From a provider perspective, only 87% of MA payments are projected to go for medical expenses.

In Wisconsin, we see Medicare beneficiaries not knowing they are MA enrollees or finding that insurers can dictate their care. We've also witnessed providers entrapped in endlessly malfunctioning insurer bureaucracies. And these are results that have occurred before these insurers gain enough market share to flip their "open" networks to closed ones.

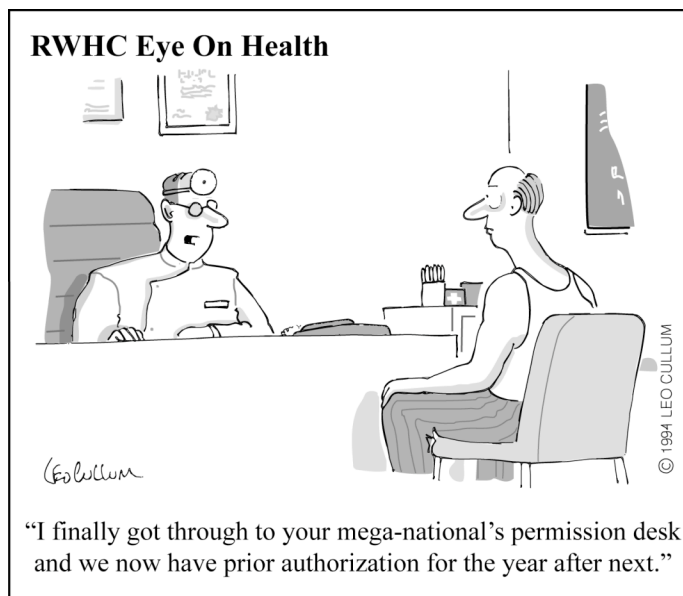
Whether this is the best way to add value for MA beneficiaries and whether it is worth the additional cost to Medicare, begs further debate. In the meantime, the Centers for Medicare and Medicaid Services (CMS) should be required to (1) mandate complete disclosure of benefits before enrollment, (2) hold all MA plans accountable for their actions with beneficiaries and providers by establishing a set of publicly reported minimum performance standards, and (3) establish clear pathways for beneficiaries and providers to register complaints and to correct problems.

Wisconsin Insurance Commissioner Sean Dilweg hit the nail on the head when he testified last May before the Subcommittee on Health of the House Committee on Ways and Means. "We need the ability to hold

companies responsible for the acts of their agents in Medicare Advantage as we currently have for all other insurance products... consumers should be able to go directly to their state insurance departments to resolve problems, rather than having to call CMS who seems to have neither the manpower nor the expertise to deal with many of these types of complaints."

As regards to the Private Fee-For-Service variant of

MA most common in rural Wisconsin, CMS should also require them to (1) offer cost-based providers the choice of a cost settlement or their interim rate plus a fixed percentage, (2) participate in quality of care reporting comparable to local health plans and provid-



ers, and (3) protect the beneficiary's right to access local services such as swing beds as they are needed.

We all need to recognize MA as the unprecedented federal subsidy it is and the potential to accommodate the take over of Wisconsin healthcare by mega-national insurers.

---

## Healthcare Quality & Safety Is No Accident

---

*From "Reaping the Harvest: A Review of the 5 Million Lives Campaign's First Year... and a Preview of What's to Come" from the Institute for Healthcare Improvement (IHI) at <http://www.ihl.org/ihl> :*

***"We set off with a guiding question: 'What is the formula for success in those hospitals that are most successful at improving quality and safety?' "***

"We had some theories in mind about what makes high-achieving organizations tick but we wanted to test them. What did we find? While there are certainly no silver bullets, here are some of the things that seem to be happening in innovative hospitals:"

***"Leaders set ambitious, system-level aims for improvement and closely track progress against these aims.*** In the facilities we visited, boards, executives, and clinician leaders proactively set their own goals for total facility or system transformation (e.g., reducing all-cause harm or risk-adjusted mortality, enhancing patient and staff satisfaction) and study their

**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.

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

[office@rwhc.com](mailto:office@rwhc.com)

<http://www.rwhc.com>

Email us with *subscribe* as Subject for free e-subscription.

progress every month, noting opportunities for improvement, removing barriers to progress, and liberally celebrating success."

***"Medical staff take responsibility for clinical improvement.*** Physicians in these hospitals join their colleagues to review data and evidence, and select areas for improvement; giving the Chief Medical Officer responsibility for quality seems especially effective in creating physician ownership of improvement."

***"The organization gives itself 'permission to prioritize.'*** Where resources are finite, organizations must make decisions about which improvement projects to select. By doing so on a quarterly or annual basis, using their system-level goals as a compass, they are observing more success, feeling more confidence, and building more capacity to take on additional changes."

***"The organization regularly and transparently reviews its performance data.*** Honest, frequent assessment of data by everyone in the organization, including front-line staff (and, often, the public), allows high-achieving facilities to stay agile, focusing energies on their most acute problems and building joint accountability for progress."

***"The organization keeps its focus on the patient (inside and outside of the hospital).*** Hospitals that view themselves as part of a larger system, consisting of other hospitals, outpatient settings, and the patient's home, provide coordinated, integrated care that comforts the patient and their family and significantly improves outcomes."

***"The organization invests in human capital and continuous learning, building capacity at all levels.*** Hospitals we visited invested significant resources in developing staff to better execute safety and quality initiatives at all levels of the organization, systematically exchanging new evidence and new approaches to managing change. In particular, supporting and developing middle managers led to strong unit-level results that tied to the larger safety and quality agenda of the organization."

***"The entire organization is aligned around a core strategy and ensures that staff members embrace this strategy.*** Hospitals used different strategies (e.g., the Model for Improvement, Six Sigma, Lean, Planetree,

ISO 9000), but in each case the organization used the strategy to unite and advance improvement efforts.”

“Taken together, these characteristics create organizations where quality is not a department, but a shared responsibility; where excellence is not defined as adherence to external guidelines, but as care for the patient that approaches perfection. How is your hospital performing in each of these areas? What can you teach the rest of the nation? Describing exactly how successful organizations achieve such complete transformation is central to the Campaign team’s upcoming work, and we encourage you to join us as we explore this—in calls, materials, and countless other learning opportunities—in the months to come.”

---

## State of States: Rural Barriers Persist

---

The following is from “Access Barriers Persist in Rural Areas” in the 2008 edition of State of the States published by the Robert Wood Johnson Foundation and AcademyHealth; the complete report is at <http://www.statecoverage.net/>:

“Approximately one-fifth of the U.S. population lives in rural areas. Rural residents are uninsured at higher rates than their urban counterparts, and are uninsured for longer periods of time than residents in urban areas. Among non-elderly rural residents, 19% are uninsured, compared to 16% of urban residents. And while more urban than rural residents report that they have never had health insurance coverage, rural residents lack coverage for longer periods of time. More than one-third of rural residents have been uninsured for more than three years, compared to just over a quarter of their urban counterparts.”

“Furthermore, research shows that rural residents who have private coverage are at higher risk of being underinsured than their urban counterparts. Generally speaking, the research categorizes individuals as being underinsured if family out-of-pocket spending for health care exceeds 10% of family income or, for low-income families below 200% FPL, out-of-pocket costs exceed 5% of family income. In fact, 12% of rural residents who do not live adjacent to urban areas are underinsured compared with 10% of rural

residents who live adjacent to urban areas and 6% of urban residents. Even when researchers controlled for socioeconomic and other characteristics, they found that the chances of being underinsured remained 70% higher for rural nonadjacent residents than for their urban counterparts.”

“For predominately rural states, the uninsured pose a significant and complex problem. In Montana and Maine, for example, more than 70% of the states’ uninsured live in rural areas. For these residents, Medicaid and SCHIP play a critical role in ensuring health care coverage. Public programs provide health care coverage to 16% of remote rural residents compared to 10 to 11% in other areas.”

“Rural areas of the country experience persistent barriers in improving access to health care services. Hospital closures, poor public transportation, and physician and dentist shortages all contribute to these barriers. Furthermore, rural residents are less likely to have health insurance because they are less likely to have employers that offer such coverage. In fact, when offered health insurance, rural residents—both those living adjacent to and not adjacent to urban areas—are just as likely to enroll in coverage as their urban counterparts.”

“State health care reforms to address the uninsured need to take into account key economic, workforce, health status, and health delivery system characteristics that differentiate rural regions from urban areas.”

**“Small businesses form the backbone of rural economy.** The disparity between rates of uninsured in rural versus urban areas may result from the fact that rural residents are more likely to work for an employer that does not offer private health care coverage, for example a small business or agricultural enterprise.”

**“Rural areas experience persistent workforce shortages.** Rural areas have fewer providers—less than 11% of physicians practice in rural areas—translating into less access for rural residents to health care services. Over 20 million rural Americans live in health professional shortage areas with a provider-to-patient ratio of 1 to 3,500 or worse. While states may be able to devise approaches for providing affordable health coverage options, poor access to services may stymie these efforts. Traveling long distances is not an effective

tive solution, particularly for the elderly. Physician workforce shortages have a disproportionate effect on already fragile rural health care infrastructures and the affordability and accessibility of coverage options.”

**“Rural residents are older and report worse health status.** Rural Americans are older and in poorer health than their urban counterparts, engage more frequently in risky health-related behaviors, and suffer slightly higher rates of chronic conditions. Fewer rural adult residents receive screening for certain types of cancer, including prostate, breast, colon, and skin cancer. Given these findings, it is not surprising that a larger proportion of rural than urban residents report ‘fair to poor’ when asked about both their physical and mental health status.”

**“Strong safety net is critical to meeting needs of rural uninsured.** States need local safety nets in rural areas to ensure the success of statewide health coverage reforms. Some states are trying to promote linkages between Critical Access Hospitals (CAHs), federally-qualified health care centers, home health agencies, and other local service providers. CAHs receive cost-based reimbursement from Medicare in order to improve their financial performance and reduce hospital closures. State-certified as necessary providers, CAHs are located in rural areas and meet geographic criteria. The federal Flex program encourages states to create a rural health plan, providing grants to states to encourage the development of rural health networks, the improvement of EMS systems, and the implementation of quality improvement initiatives.”

---

## County Governments Expand Health Agenda

---

*From “Rural Obesity Strategies to Support Rural Counties in Building Capacity” by the National Association of Counties; the complete report is at <http://www.naco.org/> :*

“The National Association of Counties (NACo) is the only national organization that represents county governments in the United States. Founded in 1935, NACo provides essential services to the nation’s 3,066 counties. NACo advances issues with a unified voice before the federal government, improves the public’s understanding of county government, assists counties in finding and sharing innovative solutions through education and research, and provides value-added services to save counties and taxpayers money.”



“As governments and institutions across our nation work to reverse the growing childhood obesity epidemic, there is an emphasis on reaching children at greatest risk—African-American, Latino, Native American, Asian American and Pacific Islander children living in low-income communities. Recent research shows that children and adults living in rural communities may also have an increased risk for obesity and require focused prevention efforts as well.”

“Rural typically has been synonymous with robust health. Today, however, many rural Americans are struggling with overweight or obesity. Research recently published in *Obesity* and *The Journal of Rural Health* reinforces what rural community leaders already know—that children living in rural areas should be recognized as a high-risk population for childhood obesity, who warrant additional attention and assistance. According to the studies, 16.5% of rural children and 20.4% of rural adults are obese, compared with 14.4% of urban children and 17.8% of urban adults. The studies also show that in addition to being at increased risk for obesity and overweight, rural children are also at increased risk of poverty, are less likely to have health insurance, are less likely to have accessed preventive care in the past year, and have lower levels of physical activity. Overall, children living in rural areas are about 25% more likely to be overweight or obese than children living in metropolitan areas. This represents a change from the past when children from metropolitan areas were at greater risk for being overweight than rural children.”



“Rural county officials are working to address obesity, the related health consequences and the unique challenges that their residents encounter. However, rural communities at times may lack the same funding, technical assistance and resources that may be available to their urban counterparts.”

“To raise awareness of this disparity and share insight from local elected leaders on the nature of obesity in rural communities, the National Association of Counties (NACo) planned and conducted the Rural Obesity Initiative. Their recommendations include:

- Support Access to Healthy Foods Initiatives
- Educate and Include the Whole Family in Childhood Obesity Prevention Programs
- Encourage Local Governments and Businesses to Consider Employee Wellness Programs
- Improve Access to Health Care with a Focus on Obesity Reduction
- Support Strong Multi-Stakeholder Collaborations”

---

## Healthier Communities: Worksite by Worksite

---

*From “ProACTIVE Wellness Initiative: Helping Wisconsin Workers Get Fit” by Candi Helseth in the Rural Monitor, Winter, 2008:*

“Employees at D&S Manufacturing in Black River Falls, WI, are healthier these days, since participating in a worksite wellness initiative.”

“Of the 53 D&S employees who voluntarily participated in the proACTIVE Wellness Initiative (pAWI) in 2006, 6 quit smoking, 20 decreased their blood sugar levels and 15 lost an average of 8 pounds each during the 9 week program. Overall, the group recorded a 5.1% decrease in both cholesterol and blood pressure levels.”

“Coordinated by Black River Memorial Hospital and funded by the Wisconsin Office of Rural Health (WORH), pAWI was developed in 2006. Liz Lund, business development manager at Black River Memorial Hospital, said surveys on community wellness behaviors and needs in 2005 had revealed that two of the top five needs related to worksite wellness.”

“ ‘Wisconsin is 22nd in the nation for adult obesity, and of the working population surveyed in Jackson County, time, energy and lack of childcare were most often cited as deterrents to maintaining good wellness habits,’ Lund said. ‘Twenty percent noted no current physical activity with 52 percent not achieving the recommended level of exercise. There was a clear need for programming to accommodate the working population.’ ”

“D&S, Black River Falls School District and Hart Tie & Lumber were the first sites selected to participate. All three businesses are located in Black River Falls, which has about 3,600 residents. pAWI began by conducting employee health risk assessments at each site. Follow-up programming was held at D&S and the school. Hart Lumber served as a control in the study, so no interventions were implemented there.”

“Employees at D&S, which manufactures large-scale components, assemblies and other metal parts, showed measurable outcomes. In addition, the employees reported positive changes such as adopting regular exercise habits, eating healthier and getting established with a health care provider.”

“ ‘I eat three healthy meals a day now and I eat better foods I didn’t eat before,’ said Emilio Juarez, a D&S employee whose cholesterol levels returned to the normal range. ‘I push myself at my job to work harder physically. I kind of make my job a game for me, to help me get more exercise and stay more fit.’ ”

“ ‘We saw successes even in the assessment phase,’ Lund said. ‘A lot of the men at D&S never went to a doctor. Many male participants had never seen a provider for preventive services. When results showed any areas of high risk, we attempted to get those individuals connected with a physician.’ ”

“A participant whose screening revealed high blood sugar was referred to a physician, diagnosed with diabetes and placed on medication. By the time he completed the wellness program, he had changed his diet and exercise sufficiently enough that he was able to stop the medication.”

“Worksite programming covered a wide range of areas, including nutrition, weight loss, cooking, exercise, fitness training, tobacco use, stress management,

depression and local wellness resources. Participants competed as teams. Coaching, weigh-ins and blood pressure checks monitored individual progress. Incentives and prizes encouraged participants to stay motivated and practice good habits at home, too.”

“ ‘Even mentally, the program helped me improve,’ Juarez said. ‘Fifteen years ago I had a brain aneurysm and it left my memory damaged. In the program, I learned some things to help me stay more alert.’ ”

“WORH funding covered participation costs for 25 participants at each work site. D&S paid employees during work hours, and also paid registration costs for the additional 28 employees.”

“ ‘We saw it as a sound investment,’ said D&S President Mike Dougherty. ‘We may not be able to quantify our investment for years down the road, but if we’re going to do something about controlling health costs, one of the best things we can do is encourage wellness among employees. Health care costs have gone from being a minor benefit cost to our third largest expense behind labor and materials.’ ”

“Employees at all three worksites experienced improvements, but improvements were higher overall in the two businesses where follow-up programs and coaching were implemented, Lund said.”

“A secondary benefit included the number of spouses and family members who made behavioral changes. Dougherty said D&S employees who hadn’t been physically active were out walking with their spouses at night. The wife of a smoker quit when he did. Most importantly, Dougherty noted, the initiative fostered long-term commitment. A D&S employee committee continues programs and incentives to maintain motivation for healthy lifestyle changes.”

“Healthier employees reduce the burden of health care costs and insurance premiums, Lund said. Through the program, area businesses are becoming more cognizant of healthy workforce benefits, such as increased productivity, reduced turnover and fewer lost workdays due to chronic illness and fatigue.”

“pAWI, which includes several community partners in addition to WORH, is bringing worksite wellness programs to additional area businesses in Jackson County. WORH and the Healthy Partnerships of Wisconsin are funding the program through February 2009.”

*For more information, contact Liz Lund, Business Development Manager, Black River Memorial Hospital, by phone 715-284-1386 or < [lundl@brmh.net](mailto:lundl@brmh.net) >.*

---

## Hospital Promotes Diabetes Self-Management

---

*Monthly, Eye On Health showcases a RWHC member story from the Wisconsin Hospital Associations’ annual Community Benefits Report. Wisconsin hospitals provide over \$1.6 billion in community benefits; twice that if you include Medicare shortfalls and bad debt. This month’s feature is from Mile Bluff Medical Center, Mauston, “Mile Bluff helps you live an active, productive, healthy life... with diabetes!”:*

### Write for the 16<sup>th</sup> Annual Monato Essay Prize

A \$1,000 Prize for the Best Rural Health Paper by a University of Wisconsin student is given annually by RWHC’s Hermes Monato, Jr. Memorial Fund. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at

[www.rwhc.com/Awards/MonatoPrize.aspx](http://www.rwhc.com/Awards/MonatoPrize.aspx)

“Diabetes is a serious, but controllable lifelong disease that affects more than 17 million Americans. It is up to individuals to take control of their diabetes before it takes over their lives and health.”

“Knowing how important it is for those with diabetes to keep up-to-date on treatment options, Mile Bluff Medical Center in Mauston provides a number of educational and support services to the community through its nationally-recognized Diabetes Self-Management Education Program. Almost all of diabetes care is self-care, and Mile Bluff teaches individuals to better control their diabetes so they are able to live life to the fullest.”

“Participants in Mile Bluff Medical Center’s Diabetes Self-Management Education Program are taught self-care skills that promote optimal diabetes management. The program is provided on an individual basis and through group sessions at Hess Memorial Hospital. The combination of support from the health care team and the knowledge gained through the edu-

cation program allows individuals to assume an active role in their diabetes management. Good control of diabetes can prevent and/or delay both short and long-term complications of diabetes.”

“The program is not only for those who have been recently diagnosed, but also those who have had diabetes for a while and have poorly controlled blood sugars, have had or need a change in medications, or those who have good control of their diabetes and want to learn to do all they can to keep it that way!”

“Mile Bluff’s education team consists of a certified diabetes educator, registered nurses, a registered dietitian, and a licensed clinical social worker. This group works together to ensure a comprehensive approach to diabetes self-management is taken with each individual that enters the program.”

“The American Diabetes Association believes that diabetes self-management education is an essential component of diabetes treatment, and has once again awarded Mile Bluff Medical Center the American Diabetes Association Education Recognition for the high-quality diabetes self-management education provided in Mauston.”

“Assuring high-quality education for patient self-care is one of the primary goals of the Education Recognition program. Participants at Mile Bluff learn to assume a major part of the responsibility for their diabetes management, which can prevent the number of unnecessary hospital admissions and some of the acute and chronic complications of diabetes.”

“Mile Bluff Medical Center in Mauston continuously strives to serve the community with the perfect balance of big-city technology and personal, small-town care by providing benefits to the community through services such as the Diabetes Self-Management Education Program.”



---

## Worksite Culture Affects Parental Roles

---

*From “Narrative Matters: Duality” by Julie R. Rosenbaum in Health Affairs, March/April, 2008:*

“I entered medicine at a time when opportunities for women in the profession were soaring. As of 2004, more than 50% of entering students were women. But despite increasing numbers of women at lower ranks in academia, as in other fields, fewer women have achieved the highest echelon, including full professorships (16%), department chairs (10%), or medical school deans (11%). In fact, given the number of women entering medicine, the accomplishments at these levels are lower than would be expected.”

“The reasons proposed for this discrepancy are many, including a glass ceiling caused by a lack of mentors, unsupportive environments, lack of flexible academic pathways, inadequate promotion and retention, and frank sexism. Of note: Women are also still paid less for the same work, even when adjustments are made for years of training, career publications, department type, and hours worked. Some have suggested that part of the gender discrepancy—in terms of achieving the highest academic posts—is because women choose to forgo professional opportunities as a trade-off for their parental obligations and pleasures.”

“To redress the gender imbalance in academic medicine, several initiatives have been developed. These include mentoring networks, flexible career paths, and more robust parental leave policies. I benefit from an institution that takes part-time work seriously, allowing my progression on my academic clock to be prorated and where I received an additional year in my current term when I had my baby.”

“Beyond parental leave, further research has discovered additional aspects of the faculty/parenting challenge. Women with children have less successful academic progress than their male colleagues or women without children. Another qualitative study corroborating this finding quotes a female department chair who notes that women who have successful family lives do not seem as likely to ascend to certain levels in academia, that all women who have reached the higher echelon are ‘divorced or lesbians.’ In fact, an experi-

ment involving volunteers pretending to be employers making decisions about hiring found that mothers, as opposed to fathers or female non-mothers, were believed to be less competent and committed and received job offers less often. When they did receive offers, the salary rate was significantly lower than for non-mother applicants. They were also deemed less likely to be promoted.”

“The immutable work of the home still takes time and effort, and it doesn’t go away when both parents work. According to the U.S. Department of Labor, even in dual-income households, women continue to take greater responsibility for housework and child care than do men, spending close to an hour and a half more each day caring for their home and family and an hour less at work.”

### RWHC Eye On Health



“No doubt about it; kids are a lot of work. That’s why I wait until they are asleep before getting home.”

involved in their families might help our children’s academic achievement and social development. These changes, however, can be achieved only through leadership and workplace policies that create environments allowing men and women to be involved in their families without the weight of cultural biases that might hinder any parent from reaching his or her full potential, either as a professional or as a parent.”

Space Intentionally Left Blank For Mailing