

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

### The Case for Primary Care Renewal & Reform

From “The Multi-Stakeholder Movement for Primary Care Renewal and Reform” by Paul Grundy et al in *Health Affairs*, 5/10:

*“The achievement of an efficient, effective, and sustainable American health system requires a vibrant primary care sector.”*

“The nation’s approach to delivering health care is inefficient, ineffective, and unsustainable. For individual patients seeking care as well as for large companies trying to stay competitive and create jobs in the United States, health care costs too much and offers too little value in return. Government and private-sector purchasers of health care are demanding systems of payment and practice reorganization that promote the comprehensive, patient-focused primary care that beneficiaries and employees require. They are launching primary care initiatives across the nation to achieve this goal, often with consumers as active partners. They are finding primary care clinicians receptive to the challenge of creating high-performance models of primary care.”

**Private Purchaser Perspective–**“Large employers seek to buy comprehensive, coordinated, integrated, accessible health care for their employees. Instead, what they tend to find is episodic, uncoordinated, fragmented, specialty-focused care that seeks to reap rewards from costly, specialized medical procedures.”

“The most erroneous stories are those we think we know best and therefore never question.” Stephen Jay Gould  
RWHC Eye On Health, 5/13/10

“According to Jennifer Baron and Alexander Muggah of the Institute for Strategy and Competitiveness at Harvard Business School, ‘Employees and their families who lack effective primary care, prevention, and chronic disease management often cannot be productive members of the workforce.’ Avoidable hospital admissions for asthma and diabetes complications are more than two times more prevalent in the United States than the average among the thirty countries in the Organization for Economic Cooperation and Development. They note ‘the United States does not do well in preventing costly hospital admissions for chronic conditions, such as asthma or complications from diabetes, which should normally be managed through proper primary care.’ ”

**Government Perspective–**“Public purchasers, contending with the same issues confronting private purchasers, are also leading initiatives to invest in and redesign primary care. The nation’s lagging clinical outcomes and high rates of avoidable hospitalizations for patients with chronic conditions are particularly salient to public purchasers. This is the case because programs such as Medicare and Medicaid cover a disproportionate share of the population with chronic illnesses.”

#### RWHC Eye On Health



Navigating the chaos of modern medicine depends on primary care no less than flying depends on air traffic controllers.

“Because Medicare is the largest single buyer of care, many companies, such as IBM, buy health care the same way Medicare does. Private payers often base their physician fee schedules on the Medicare resource-based relative value scale, thereby extending the widening gap in Medicare compensation for primary care and specialty services.”

“In drafting health reform bills in 2009, legislators in the House and Senate included a variety of measures to strengthen primary care, such as increases in Medicare and Medicaid fees for primary care, medical home demonstration programs, increased funding for National Health Service Corps primary care scholarships and loan repayment, incentives for recruiting students into rural medicine, and a primary care extension program to support practice improvement. With the enactment of health reform legislation in March 2010, those steps now have the force of law behind them.”

**Consumer Perspective**—“Consumers experience frustration and adverse health outcomes as a result of fragmentation of care and difficulty gaining access to primary care. ‘Where Have All the Doctors Gone?’ queried a headline in the 2 September 2008 issue of *AARP Today*, relating the plight of seniors unable to find a primary care physician. A Harris poll from that same month found that 67 percent of U.S. adults rated as extremely or very important ‘the ability to have a relationship with a doctor who takes a whole-person approach to patient care (social, mental and physical care) and who provides care for all levels of health.’ More than half, or 56 percent, reported ‘difficulty navigating the healthcare system for themselves and/or their family members.’ ”

“Testifying at a May 2009 Senate Finance Committee hearing, AARP president Jennie Chin Hansen stated, ‘Effective practice models that emphasize, encourage, and improve primary care should be expanded and incentives should be created to encourage individuals to

practice in primary care. ...Strengthening the primary care workforce is an essential part of ensuring the provision of quality affordable health care for all.’ ”

**Primary Care Clinician Perspective**—“Primary care clinicians often feel undervalued and overwhelmed. They experience a paradox: Primary care is more important than ever in the twenty-first century, but the approach to delivering it is stuck in the early twentieth century. A growing array of evidence-based interventions can be applied in primary care settings to prevent disease, manage chronic illness, and alleviate suffering. At the same time, the coordinating role of primary care has taken on added value in proportion to the increasing complexity of modern health care. And health information technology (IT) makes possible new ways to communicate with patients over space and time, integrate care, and measure and manage the care of a defined population of patients.”

“Despite these advances, investment in primary care has lagged in the United States. This inattention is seen not only in the widening gap in earnings between primary care physicians and specialists, but also in the undercapitalization of primary care practices. A 2009 Commonwealth Fund survey found that fewer than half of primary care physicians in the United States had an electronic health record in their offices, compared with more than 90 percent of primary care physicians in most European nations surveyed. U.S. primary care physicians were also much less likely than their European counterparts to have practice teams that included nonphysicians collaborating on chronic care.”

**RWHC Eye On Health** is the monthly newsletter of the Rural Wisconsin Health Cooperative, begun in 1979, has as its **Vision** that rural Wisconsin communities will be the healthiest in America. Our **Mission** 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.

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“Primary care physician organizations have endorsed getting their own medical house in order. The American Academy of Family Physicians’ Future of Family Medicine project called for new models of practice. The academy invested resources to develop the TransforMED center to facilitate and provide technical assistance for a national demonstration project of practice transformation. Other primary care physician organizations have mounted their own primary care improvement programs.”

### *Challenges and Opportunities*

“The compelling case for primary care, the development of a coalition of diverse stakeholders to advocate for primary care, the promising examples of innovators implementing advanced models of pri-

mary care, and the evidence that purchasers and payers are beginning to invest in more-systematic transformation of primary care all bode well for the renewal and reform of U.S. primary care. Will this movement be transformative, creating a renaissance in primary care, or will it falter at the stage of early adopters and demonstrations?”

**Need For More Resources**—“One key driver of sustained change will be the dedication of more resources to primary care, to increase primary care compensation and to support and reward enhanced models of primary care. Concerns about the high costs of health care in the United States are likely to make this a zero-sum game for the most part. Many purchasers and payers expect that there will be offsetting savings in other health sectors for the additional investments made in primary care. However, this expectation will present political and policy challenges. A recent Medicare fee schedule revision that modestly increased primary care fees and reduced fees for imaging and certain procedural services in cardiology and other fields was greeted warmly by primary care specialty societies but was roundly criticized by several specialty societies. The recently enacted health reform legislation will also boost payment for primary care under both Medicare and Medicaid. But how much further policy makers will push to revalue fees from specialty to primary care remains to be determined.”

**Short-Term Savings**—“In addition, many public and private purchasers that have agreed to pay more for medical home pilot programs have done so with the expectation that these programs will yield a short-term return on investment, in the form of reduced expenditures for emergency department visits and hospitalizations. Although some of the early programs have shown such favorable results, many primary care advocates believe that the economic benefits of primary care accrue over the long term. They say that it is unrealistic to expect primary care reforms to yield short-term savings from year to year in the face of the many inflationary pressures affecting the health system. There is worry that purchasers’ enthusiasm for primary care reform will wane if short-term savings fail to materialize.”

**Better Medical “Neighborhood”**—“There is also concern that even the best medical home might not achieve its promise of better health care value if located in a medical ‘neighborhood’ of hospitals and

other provider organizations that resist integration of care and responsible stewardship of health care resources. In that case, primary care renewal may need to be linked to other reforms, such as accountable care organizations, to reorient incentives and values across all health care tiers.”

“Questions also remain about whether widespread transformation can occur across the small, independent offices and clinics where most primary care is delivered in the United States. Currently, successful scaling-up of new models of primary care is largely happening in integrated delivery systems. In nations with robust primary care systems, single-payer or coordinated all-payer systems have provided a means of implementing systematic reform of primary care, such as

#### **Joint Principles of the Patient Centered Medical Home**

Adopted February, 2007 by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and American Osteopathic Association

The Patient Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family.

**Personal physician**—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

**Physician directed medical practice**—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

**Whole person orientation**—the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

**Care is coordinated and/or integrated** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

**Quality and safety** are hallmarks of the medical home.

**Enhanced access** to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

**Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

system-wide rollout of electronic health records and payment reforms. The more diverse payment and delivery systems in the United States make implementing such broad transformation more difficult.”

**Importance of Primary Care**—“Despite these challenges, a consensus has emerged that primary care is ‘too important to fail.’ The goal of a more affordable, effective, equitable, and sustainable health system for the American people cannot be achieved without renewal and reform of primary care. Talk about the importance of primary care is hardly new in the United States, yet the nation’s health system has been remarkably resistant to past efforts to reshape it on a solid foundation of primary care. The unprecedented coalescing of diverse stakeholders around a forward-looking vision of revitalized primary care augurs well for a far different outcome than in the past.”



“While that sounds like a clear choice, the health improvement plan has a lot of requirements. First, participants must sign a two-page contract, which lays out the ground rules: They must have a primary-care physician. They must complete a health-risk assessment, biometric screening and a health learning course annually. Health learning includes topics such as how to prepare for a physician visit and conduct self-exams. If, through these screenings, the employee or spouse is flagged for health intervention, they must participate in and complete relevant programs. If a nurse from the employer’s contracting agency reaches out to a worker, he or she must talk to the nurse and comply with any recommended interventions.”

“To be clear, the employees don’t have to improve their health, they just have to participate. So, if you are a smoker, you have to at least try to quit.”

“ ‘We’re using behavioral economics to incentivize people to improve their health,’ said Hank Scheff, director of research and employee benefits at AFSCME Council 31. ‘We try and tailor this to the individual. ... It’s a great platform that you can add to.’ ”

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## Union Succeeds with Wellness Incentive

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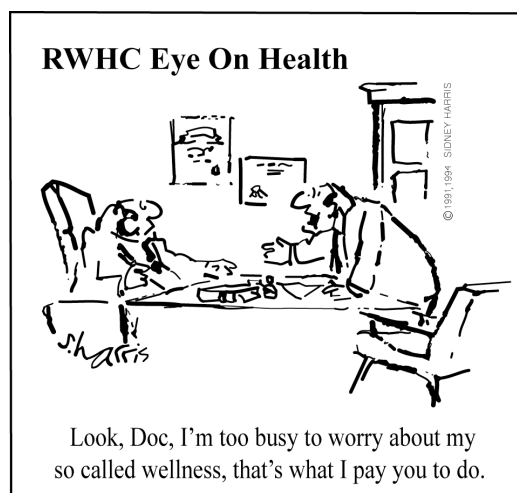
From “For good behavior—More employers, insurers are getting on the behavioral economics bandwagon to influence—not force—people to make healthy choices to cut costs” by Rebecca Vesely in *Modern Healthcare*, 5/10/10:

“One small employer in Illinois with just 360 covered lives has embraced these concepts since 2007. Council 31 of the American Federation of State County and Municipal Employees, a labor union representing workers throughout Illinois, incorporated behavioral economics into its plan design for its own employees, spouses and dependents.”

“The way it works at Council 31 is employees have two options: the standard plan, with typical PPO benefits and copayments, or the much more generous health improvement plan. The standard plan costs workers about 3% of their salary while the health improvement plan is free for employees and 1.5% of their salary for spousal (or same-sex domestic partner) coverage.”

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“Implementation of this program, Scheff said, was bumpy. Still, in the first year 90% of adults signed up. Today, about 95% are in the health improvement plan. Also unusual about these benefits is that each adult in the household must sign up separately. So, the employee could choose the standard plan, while the spouse could choose the health improvement plan. All covered children are automatically enrolled in the cheaper health improvement plan but aren’t compelled to meet the requirements.”



“Prior to 2007, the union was seeing steady double-digit increases in medical claims. (It is self-insured, with a provider network through Blue Cross and Blue Shield of Illinois.) But since implementation in January 2007, paid claims have been flat, and are below 2006 levels, Scheff said. With four years of health assessment data from workers, the union also is starting to see movement in risk factors such as smoking, weight loss and chole-



terol. More than 40% of smokers reported that they have quit. Still, it hasn't worked for everyone. In the first year, four people were removed from the health improvement plan because they failed to participate in screenings."

" 'We're not trying to play gotcha,' Scheff said. 'Where we have trouble with people is that they don't do the program, they procrastinate. We say, either make the commitment or not. It's your choice.' "

"Perhaps most important to AFSCME is that employees are more active participants in their health, said Ray Werntz, senior consultant at HPN WorldWide, which developed the program with AFSCME."

" 'What we make clear is we want people to deeply engage in their health,' Werntz said."

#### 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/)

system—came together to achieve an historic agreement with the Obama Administration to change the way Medicare reimburses."

"Department of Health and Human Services Secretary Kathleen Sebelius will convene the National Summit on Geographic Variation, Cost, Access and Value in Health Care to explore and develop solutions to the Medicare geographic disparity issue later this year."

" 'Late at night in the days leading up to this spring's historic health care vote, the Quality Care Coalition secured critical changes to

the health care bill that have the potential to revolutionize the way Medicare does business,' Braley said. 'The Quality Care Coalition will play a critical role in making sure the Obama Administration continues working toward a reimbursement model that ends geographic disparities and finally rewards doctors for providing high-quality care, rather than performing unnecessary procedures.' "

### New Congressional Quality Care Coalition

From a Washington, DC, Press Release on 4/21/10; for more information call Leah Hunter in Congressman Ron Kind's office at (202) 225.5506.

"The official formation of the Quality Care Coalition was announced by Reps. Bruce Braley (D-Iowa), Betty McCollum (D-Minn.), Jay Inslee (D-Wash.) and Ron Kind (D-Wis.). The Quality Care Coalition will provide Members of Congress a forum to transform the health care system to reward value in care and make evidence-based, quality care the standard regardless of location in the United States. The Coalition will also continue to address geographic variation in Medicare reimbursement for seniors."

"During health care reform negotiations, a group of more than 30 Members of Congress—representing areas penalized by the current Medicare payment

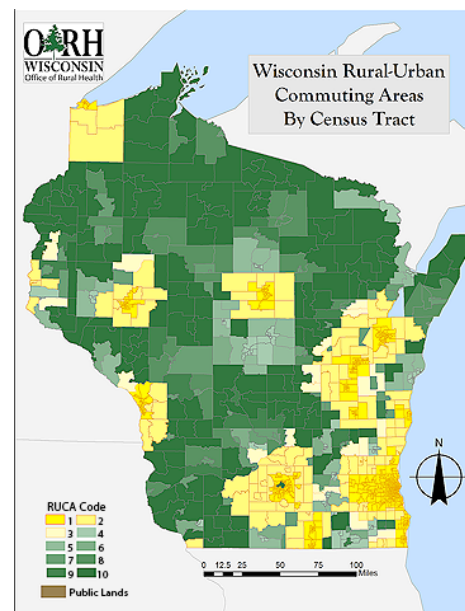
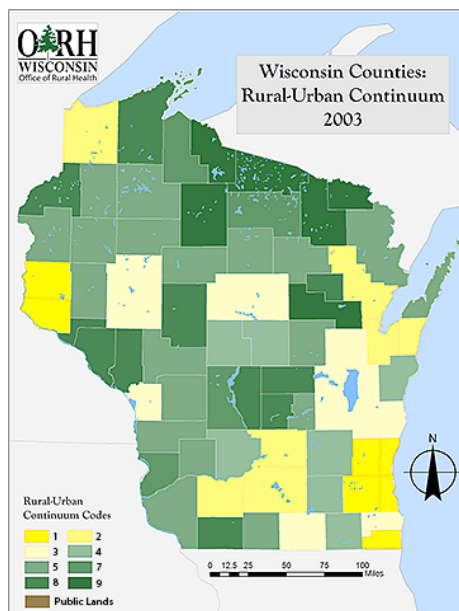
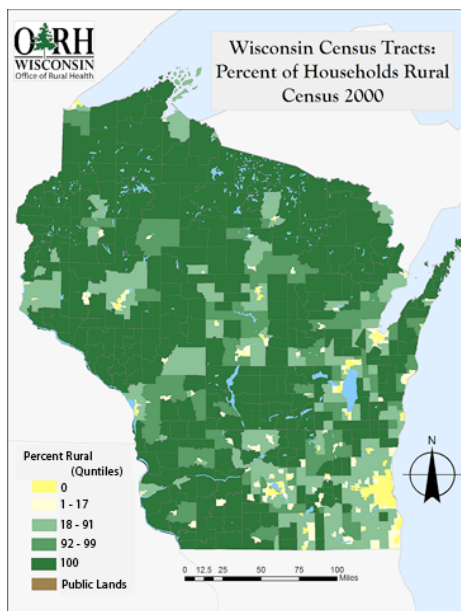
" 'Medicare is responsible for providing health care to 45 million Americans,' McCollum said. 'My commitment is to ensure that Medicare patients all across America receive high-quality health care and improve patient outcomes. This Coalition will continue to work with Members of Congress and Obama Administration to prioritize the best value in health care delivery.' "

" 'Changing the health care system to lower costs and improve care hasn't been easy nor is it finished,' In-

slee said. 'Working together we were able to create solutions that will reorganize the way we pay for health care, rewarding quality of outcomes rather than just quantity of services. The Quality Care Coalition will continue to be a leading voice in Congress on addressing bloated health care spending and bending the cost curve, in order to ensure better patient outcomes and economic viability. Forming this Coalition is our way of saying quality care is a long term effort, and we are in it for the long haul.' "

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## Rural is in the Eye of the Beholder and the Applicable Statute or Regulation

Thanks for the maps to Shaun Golding, Epidemiologist, Wisconsin Office of Rural Health

“ ‘A value-based reimbursement system benefits all states and all regions,’ Kind said. ‘As the Quality Care Coalition, we’ve begun to reform our health care system in to one that puts quality before quantity, keeps our best interest in mind, and keeps costs under control. We’ve taken significant strides to change the way we pay for health care in this country, but there is more work to be done in promoting quality and value in our Medicare system. I look forward to working with my colleagues to make sure implementation of the health care reform bill achieves the objectives we fought so hard to include.’ ”

*community health centers and Critical Access Hospitals,” said Mary Wakefield, HRSA Administrator.*

“Critical Access Hospitals (CAH) and Federally Qualified Health Centers (FQHC) are types of health care providers so designated by the Federal government. The central point of this manual is to illustrate that through cooperation and collaboration, CAHs and FQHCs, particularly those in close proximity and serving similar communities, can better meet community need, enhance each other’s roles, and stabilize and expand needed services. Although directed at FQHCs and CAHs, many insights on collaboration can be applied to small rural hospitals and FQHCs serving similar communities.”

### The Need for CAH-FQHC Collaboration

A Manual on Effective Collaboration Between Critical Access Hospitals and Federally Qualified Health Centers has just been released by the Federal Health Resources & Services Administration’s Office of Rural Health and is available at:

[www.hrsa.gov/ruralhealth/pdf/qhcmmanual042010.pdf](http://www.hrsa.gov/ruralhealth/pdf/qhcmmanual042010.pdf)

*“With health centers and Critical Access Hospitals both facing increasing demand for services, the need for collaboration has never been greater. Our goal, at HRSA, is to encourage strong partnerships between*

### Got Y?

From the RWHC newsletter *Leadership Insights* by Jo Anne Preston, RWHC Workforce & Organizational Development Manager, 4/10:

“As a child, when I would complain about how early we had to wake up to get on the school bus, my dad would say, ‘When I was a kid we had to WALK 5 miles to school and it was uphill both ways!’ Seems every generation wants the next one to pay their dues

too. We are probably doing the same thing to our Gen Y'ers today. Generation Y, (those born from *about* 1980-1995)...AKA Gen Why, Millennials, Boomerang (*hey parents, just because they moved out doesn't mean they won't move back in*), Gen Net-the young generation that is currently turning the workplace on its heels."

"The #1 complaint I hear (and have said it myself) is '**They act entitled**'. Hey, hasn't every generation so far had it better than their parent's generation? We who birthed these Y'ers created their feeling of entitlement by reminding them constantly that they can do anything-it makes sense that they believe it. What appears as cockiness can be just expectations of greatness. *Is that really so bad, that a young person expects great things?* The rub comes when generations view workplace norms very differently from each other, and feel as though their own view is the way it 'ought' to be. 'I'm right and you're wrong' is not a helpful stance in resolving conflict. One of my favorite coaching tips is to ask 'do you want to be right or do you want to be effective?' **Here are 10 tips for effectiveness with Gen Y:**

**① Develop a relationship with them.** Gen Y'ers may not be loyal to a corporation like previous generations, but a real relationship with a manager is critical to their feeling of connectedness. (*Take your Gen Y staff out for a latte and find out what makes them tick*).

**② Help them understand** how what they are doing is helping them to advance in your organization. This means having conversations regularly about their work, why it matters, how it can help them grow. **3**

**③ Give more frequent feedback,** more face to face time. Once a year performance reviews won't cut it. Think of this mentoring and feedback as your job as a leader, not as work *in addition to* your job.

**④ Create benchmarks for progress,** hand-hold more with what the expectations are, reinforce progress.

**⑤ If there is not going to be an open position** for them to advance to quickly, look at alternative ways to switch up the job. Expect that if you don't, they will leave for opportunities that look like advancement.

**⑥ Teach them to be your boss!** They may be someday. Spend time with them mentoring them.

**⑦ Use their orientation towards teams to manage their work.** Where can you create team building opportunities so that they stay connected?

**⑧ Have a party their first day of work** (not on the day they leave).

**⑨ OMG, keep an open mind** to what Y'ers can teach you about technology and the benefits of connecting in new ways. BTW, Gen Y may be less tech savvy than they are tech 'unafraid'. We can learn from them about taking risks, trying new things.

**⑩ Hold people accountable to expectations,** yes; and also ADAPT. Every new generation has had an amazing impact on the world of work, this one will too."

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

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## RWHC Corporate Partner: Unity

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*For more information on the featured corporate member or to inquire about our corporate membership program, please visit [www.rwhc.com](http://www.rwhc.com), or contact Dave Johnson: 608.644.3227 or [djohnson@rwhc.com](mailto:djohnson@rwhc.com)*

Although Unity Health Insurance is one of the newest participants in the RWHC Corporate Membership program, they have a longstanding relationship with rural entities. Formed in 1983 as HMO Wisconsin, Unity has grown to include over 90,000 members from the same communities as many of the RWHC Member hospitals. Unity has received three NCQA Excellent Accreditations since 2002, and for the last four years has earned a "Top 50 US Health Plan" designation from *US News and World Report*. Unity is also recognized as a leader in Wellness Services to local communities. For more information regarding Unity Health Insurance, please contact Kurt Popp 800.362-3310 or [www.unityhealth.com](http://www.unityhealth.com).

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## Untiring HIM Advocate Receives Top Honor

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**The Wisconsin Health Information Management Association 2010 Educator Award** was presented to Sheila Goethel, RWHC Coding Consultant. This award honors those who demonstrate excellence in preparing the next generation of HIM professionals for their careers. It can be awarded to those who teach in H.I. administration, technology, and other related programs, and those who are involved in WHIMA's activities at a state and local levels."

"Sheila is an RHIT and holds a CCS credential. Sheila has provided loyal service to WHIMA and the HIM profession for over 30 years. She has worked at the Rural Wisconsin Health Cooperative for the past 10 years as a Coding Consultant, prior to that she was at Amphion as a Coding Consultant and prior to that at St. Clare Hospital in Baraboo for several years."

"She has displayed innovation in the development and presentation of webinar (Mediasite) educational programs on coding topics that have been offered to WHIMA members for continuing education. Not

only is she using current distance education technology, she is also a leading coding expert sharing her knowledge with many others in the HIM profession."

"Sheila has been a conference and workshop presenter for many years and is always willing to share her knowledge about coding and reimbursement systems. She is a respected presenter and continues to be asked to provide education to WHIMA members."

"She has served on various WHIMA teams and committees. She has served on the WHA Hospital Inpatient Quality Indicators Workgroup, Metastar Advisory Committee, and the MATC Advisory Committee. She also participates in the education of students by serving as guest speaker in courses in the Medical Coding Specialist Program at MATC."

"No matter what she is doing, Sheila continuously models the WHIMA values of excellence, innovation, and professional growth. She strives to do her best and continues to learn and grow. She's an excellent role model for WHIMA members."

"We truly appreciate learning from Sheila and appreciate her contributions to our profession."

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