

NEWSSEEN



SELECTED HOSPITAL NEWS STORIES AND EDITORIALS THAT HAVE APPEARED IN PRINT

Volume 32, Number 17

August 27, 2010

Milwaukee Journal Sentinel
8/11/10

Court says outpatient center must pay property tax

Wheaton Franciscan says it plans to appeal ruling

By GUY BOULTON
gboulton@journalssentinel.com

The state Court of Appeals ruled Tuesday that Wheaton Franciscan Healthcare's outpatient center in Wauwatosa was not exempt from property taxes, reversing a district court decision in a case closely followed by other health care systems.

Wauwatosa had challenged Wheaton Franciscan's contention that its outpatient center at 201 N. Mayfair Road was an extension of Wheaton Franciscan Healthcare-St. Joseph hospital in Milwaukee and therefore exempt from property taxes.

Anne Ballentine, a spokeswoman for Wheaton Franciscan, said the

health care system was surprised and disappointed by the decision.

Wheaton Franciscan, she said, plans to appeal the decision to the Wisconsin Supreme Court.

"We continue to maintain that the majority of the facility is dedicated to hospital-based services as an extension of Wheaton Franciscan-St. Joseph," Ballentine said.

The nonprofit health care system, affiliated with the Catholic Church, also reinvests all of its net income in the communities it serves, she said.

The tax dispute involved \$2.9 million in property taxes paid in part of 2003 through 2006. Two floors of the building are devoted to medical offices, and Wheaton Franciscan never sought tax exemptions for that part of the building.

The Milwaukee County Circuit

Court supported Wheaton's position after a nine-day bench trial in August 2007 and early 2008. In a dissenting opinion, Court of Appeals Judge Ralph Adam Fine also agreed with Wheaton's position.

The outpatient center's services include cardiology, pulmonology, surgery, pain management, radiology, physical therapy and a sleep disorder center.

It also includes an urgent care center — though one that differs significantly from what most people consider urgent care because its physicians bill at rates similar to those at hospital emergency departments.

In their opinion, two of the three appeals court judges noted the outpatient center's set hours, its focus on outpatient care and its policy of not accepting ambulances trans-

porting patients with emergency conditions.

They determined that the clinic was essentially a doctor's office and therefore subject to city property taxes.

But Laura Leitch, general counsel of the Wisconsin Hospital Association, said many conditions that once required patients to be hospitalized now can be treated on an outpatient basis.

"We need to be able to provide the services in the most efficient and effective manner," Leitch said.

The hospital association filed a brief supporting Wheaton Franciscan.

The League of Wisconsin Municipalities and the Wisconsin Association of Assessing Officers filed briefs supporting Wauwatosa's position.

Green Bay Press Gazette
8/19/10

\$30 million targeted for rural broadband

UW-Extension gets stimulus funds

BY LARRY BIVINS
Press-Gazette Washington Bureau
lbivins@greenbaypressgazette.com

WASHINGTON — As many as 139,000 households and 9,000 businesses could benefit from nearly \$30 million in new economic stimulus funding announced Wednesday to expand high-speed Internet service in rural Wisconsin.

The money will go to the University of Wisconsin-Extension for a project to link 182 community institutions — including colleges, health-care facilities, government buildings, libraries, public safety agencies and K-12 schools — in the Chippewa Valley region, Platteville, Superior and Wausau.

UW-Extension also will get \$2.4 million to create seven public computer centers that could serve as many as 3,000 users a week in those areas as well as the Menominee Nation.

The funding from the Commerce Department is part of \$1.8 billion being distributed to 37 states as part of President Barack Obama's effort to close a technology gap in rural and underserved communities.

"These projects will connect Americans who have for too long been without the full economic, educational and social benefits of high-speed Internet access, access central to success in the 21st Century," Commerce Secretary Gary Locke said.

The Obama administration also awarded \$3.3 million to the College of Menominee Nation to develop 130 new computer work stations, increase operating hours and train as many as 2,500 residents. And the administration awarded \$2.5 million to the city of Milwaukee to train up to 5,000 residents and create 270 new work stations.

With its \$30 million infrastructure grant, UW-Extension plans to lay more than 600 miles of new fiber-optic cable to serve 39 communities under its Building Community Capacity through Broadband project.

The funding "gives us an opportunity to fully explore what the potential for broadband is in a variety of communities," said Marv Van Kekerix, interim UW-Extension chancellor.

Vice Chancellor Christine Quinn cited practical uses of high-speed Internet for public safety agencies, saying firefighters on their way to a building could use the service en route to learn about the building's wiring. Broadband also would enhance telemedicine, she said, by putting medical experts a mouse click away.

Both Wisconsin senators hailed the announcement, saying the investment will create jobs and opportunities for many.

"Reaching new markets enables businesses to grow and create new jobs. But the reality is that there are many underserved populations, even in urban areas, that don't have access to the broadband services that extend their reach," Sen. Herb Kohl, D-Milwaukee, said.

Sen. Russ Feingold, D-Middleton, said the grant "is another great example of the stimulus not only creating jobs in the near term, but helping economic development and job creation over the long term."

Gov. Jim Doyle spoke of the grant's advantages.

"Access to quality broadband service and training are critical to the future of the state's commerce and education system," Doyle said.

Newsweek
8/16/10

Wisconsin Makes Nice on Medicaid Cuts

By Ryan Tracy

Medicaid is a lifeline for millions of uninsured Americans. For public officials, however, it's often a quagmire—a program that drains as much as a quarter of total state spending, yet can't be streamlined without political bloodshed. Previously, states have tried to rein in costs by pruning "optional" benefits (such as adult day care), reducing payments to health-care providers, or raising taxes, none of which are attractive choices in the era of the perpetual campaign. Could Wisconsin have a better way?

Last year Gov. Jim Doyle proposed to slash \$400 million from the state's health-care system, one of the country's most comprehensive. But rather than oversee the cuts, he and the state legislature left them up to Medicaid officials, who not only found the savings but expanded enrollment. The fixes, most of which kicked in this summer, were a predictable mix of new contracts and procedures (incentives for natural birth will save \$4 million in C-sections). But the approach upended traditional politics. Lobbyists lost influence, officials were insulated from blame, and lawmakers were shielded from "tough votes," says Steve Brenton, president of the Wisconsin Hospital Association. Best of all: voters seem to be happy. "We by no means have the exclusive answer," says Doyle, whose staff got calls about the idea from around 10 other states. But anything, he says, is better than "all those political battles."

USA Today
8/24/10

Get ER wait times on your phone, online — even on the road

Updates meant for less urgent cases to help hospitals spread patient load

By Lauran Neergaard
The Associated Press

Need an X-ray or stitches? Online, via text message or flashing on a billboard, some emergency rooms are advertising how long the dreaded wait for care will be, with estimates updated every few minutes.

It's a marketing move aimed at less urgent patients, not the true emergencies that automatically go to the front of the line anyway — and shouldn't waste precious minutes checking the wait.

"If you're in a car accident, you're not going to flip open your iPhone and see what the wait times are," says Sandra Schneider of the American College of Emergency Physicians.

Despite that fledgling trend, ERs are getting busier, forcing them to try innovative tactics to cut delays. And in 2012, hospitals are supposed to begin reporting to Medicare how fast their ERs move certain patients through, a first step at increasing quality of care across the board.

"The longer people stay in the emergency department, the more likely they're going to have complications, deaths. If they're elderly, they're more likely to end up in a nursing home," says Nick Jouriles, emergency medicine chief at Akron General Hospital in Ohio, among the hospitals that post estimated wait times.

ER visits hit a new high of more than 123 million in 2008, up from 117 million a year earlier, says

preliminary data released this month by the Centers for Disease Control and Prevention. A disturbing report last year from Congress' investigative arm found that too often, patients who should have been treated immediately waited nearly half an hour.

So why post wait times that might encourage people who otherwise could have tried an urgent-care center?

There are no statistics on how many hospitals advertise wait times, although they tend to have multiple ERs in a region. The idea: People with less urgent conditions might drive a bit farther for a shorter wait, possibly helping a hospital chain spread the load without losing easier cases to competitors.

Jouriles is beginning a study to see if the postings make a difference in patient volume, the time spent in the ER and satisfaction.

Perhaps more common than posting wait times are other attempts at easing the traffic jams:

► In Nashville, Vanderbilt University Medical Center does "team triage," with a doctor, nurse and paramedics manning the ER's front door. They work the waiting room, ordering blood work or X-rays so that less urgent cases — like a sprained ankle —

may be diagnosed without ever tying up an ER bed and more complicated ones get a head start on diagnosis that can save 40 minutes a person.

► The main cause of ER crowding isn't an influx of sprained ankles but a lack of hospital beds for patients so sick they need to be admitted, leaving them "boarding" in the ER so there's no room to bring in new patients, says Peter Viccellio of the State University of New York at Stony Brook. Mondays, when most hospitals fill inpatient beds with elective surgeries, are especially bad.

Viccellio pioneered "hallway medicine" to ease boarding, where patients are divided on gurneys among the hospital's wings to await available beds. Distributing the load shortened total hospital stays by a day, possibly as patients benefited from more nursing attention, he says.

Employers amp up health programs

Offering disease management tools may cut costs

BY HIRAN RATNAYAKE
The (Wilmington, Del.) News Journal

AND RICHARD RYMAN
ryman@greenbaypressgazette.com

When choosing what to eat, Monica Loutzenhiser opts for an apple over nachos or a salad over a burger.

She wants to eat a nutritious diet and stay healthy. Her employer wants the same thing.

Loutzenhiser works for AstraZeneca, which is among a growing number of companies to offer workers disease-management programs — such as handing out pedometers, calorie counting or monitoring cholesterol levels online — as a means of controlling health benefit costs.

"It makes you more aware of what you're doing," said Loutzenhiser, a human-resources manager who tracks the amount of calories she ingests each day through one of the programs. "If I go out for dinner and have a bowl of cheese fries, I'm going to see the impact of that."

Nearly 60 percent of large employers offered at least one disease management program in 2008, according to the Center for Health Systems Change, a nonpartisan policy research organization. The Partnership to Fight Chronic Disease — a nonprofit that represents disease management companies — projected that the programs could save Medicare \$652 billion in the next decade.

But the lingering question is whether there's sufficient evidence that they save money in the long run — or even improve workers' health.

Randy Connour, executive director of Healthy Lifestyles Cooperative in Green Bay, said it's hard to measure the effectiveness of the programs, both because it's difficult to determine metrics and because the studies only measure those who participate. On the whole, they tend to be the healthiest people to begin with.

"You've got to get into the 20 percent (of employees) that cost you the most money," he said.

Connour said 73 percent of the employees of businesses that are members of Healthy Lifestyles participate in wellness programs, compared with less than 25 percent

nationally.

A key element of the cooperative's philosophy is that healthier members will lead to fewer claims and better financial results, including more constrained, if not reduced, premiums. Its contract with Humana Inc. includes incentive-based premium setting.

"Employers understand that there is no question that it makes sense at some level," he said. "As far as we know, not one study has ever shown that it makes no sense. It is a 10-1, 15-1 return on investment? No study shows that. The best study shows a 3-1 or 4-1 return on investment."

Provisions in the new health-care reform law call for an expansion of disease management programs in the private and public sectors in 2014.

But a review of studies of such programs did not come to a consensus that they work, according to Mathematica Policy Research Inc., based in Princeton, N.J.

One of the reviewed studies, published last year in the *Journal of the American Medical Association*, involved nearly 20,000 Medicare beneficiaries in 15 programs nationally. The study, run over three years and involving more than 18,000 patients, found that disease-management programs increased costs but didn't show a significant drop in hospitalizations.

General Electric decided not to expand a disease-management program because it wasn't seeing any compelling evidence that it was saving money — or substantially improving workers' health.

Although not matching the breadth of the JAMA study, smaller studies on such programs have yielded positive results.

That's why "the jury is still out," said senior fellow Deborah Chollet, who co-authored the Mathematica report. "In some ways, it helped people, but we don't have enough studies to distinguish which (ones) don't work and which ones have the greatest effect."

In any event, employers are running out of options to contain costs, Connour said.

"We've had 60 or 70 employers in the last month telling us they've done everything they can do. The only thing left is really helping people reduce risk and probably reduce risk through exercise. There is nothing else."

Healthy Lifestyles has 70 company members with 1,500 participating employees.

USA Today

8/16/10

Glimpse the future of primary health care

Innovative programs counter doctor shortage

By Rita Rubin
USA TODAY

About 65 million Americans live in communities with a shortage of primary care doctors, physicians trained to meet the majority of patients' health care needs over the course of their lives.

How much more difficult will finding a primary care doctor become as a result of the recently passed health care overhaul legislation, which will extend coverage to an estimated 34 million currently uninsured Americans by 2019?

Massachusetts, which in 2006 passed a law that led to nearly universal coverage of its 6.6 million residents, might provide some clues.

In that state, fewer and fewer internists and family practice doctors are taking new patients, and wait times to see family practice doctors are lengthening, according to the Massachusetts Medical Society and the non-profit Massachusetts Health Quality Partners.

Even before Congress in March passed the landmark law designed to make health care more affordable and expand coverage, an aging population and doctors' increasing preference for higher-paying specialties set the stage for a primary care shortage. And what many believe to be an outdated reimbursement system — one that drives doctors to schedule office visits when a quick phone call or e-mail might do — doesn't help.

The shortage of primary care doctors could lead to longer waits not only for primary care, but also for specialty care as well as greater use of expensive emergency rooms for non-emergencies, researcher Walt Zywiak of Computer Sciences Corp., an international consulting company headquartered in Falls Church, Va., noted in a July report.

But some innovative programs provide a glimpse of what the future of primary care — a future in which a one-on-one visit at the doctor's office takes a back seat — could look like. They include:

► A Portland, Ore., practice where doctors provide more care via the phone or e-mail than face-to-face.

► A Massachusetts practice that offers "shared medical appointments" for six to 14 patients.

► A Philadelphia clinic in which nurse practitioners, who have earned master's or doctorate degrees and have trained in the diagnosis and management of health problems, provide primary care.

Better communication

GreenField Health, founded in Portland in 2001, gets its name from a *Harvard Business Review* article in the early 1970s, chief operating officer Steve Rallison says. If you could create a business from scratch, it said, you'd start with a green field.

GreenField Health has leveled the playing field as far as how its doctors — five internists, one family practitioner and one pediatrician — care for patients. "We're not going to be caught in the tyranny of the visit," Rallison says. "The pressure for most internists, family physicians, is they have to see lots of patients to generate revenue."

More often than not, GreenField's doctors answer questions and resolve problems, such as interpreting test results or adjusting medications, without seeing patients. Office visits make up only a quarter of their work effort, Rallison says, with phone calls 35% and secure messaging 40%. Doctors get to know patients with 90-minute initial visits. Annual visits are an hour, follow-ups a half-hour.

How can GreenField afford to do this, given that insurers usually don't pay doctors to talk on the phone or send e-mails? Patients pay an annual "retainer fee," from \$350 to \$650, depending on the patient's age, to cover what insurance doesn't.

Before joining the practice in 2002, internist Cynthia Ferrier had always been in a traditional fee-for-service — or fee-for-office visit — practice. She'd see 20 to 25 patients a day and usually would be late for every appointment except the first because they ran over the allotted time. Responding to patients' e-mails was out of the question. At GreenField, which doesn't have a waiting room, Ferrier sees eight to 10 patients a day. She answers phone calls and e-mails between appointments.

Colleagues at her old practice warned she'd be swamped with phone calls and e-mails. "You're going to get every worried crazy person out there," one told her. But that hasn't happened, she says. Because they know they can get a timely response, patients aren't bombarding her with questions.

Shelly Holly, 46, of Portland, says her \$400 annual retainer fee is well worth it.

Holly, an environmental planner, liked her former doctor, but didn't like how long she had to wait for an appointment or how long she had to hang out in the waiting room.

When she heard about GreenField, "it just seemed to make sense. My time is valuable, too."

With her GreenField doctor, "if I have questions ... I just slip out my iPhone and type out an e-mail and e-mail it to him. Lo and behold, I might get an answer back in 20 minutes."

Help for doctors

GreenField Health may be a model of the practice of the future, but it's not typical today, Philadelphia internist Richard Baron says. Compared with many cities, he says, Portland is fairly affluent, so it's easier to attract patients who can pay a retainer fee.

"In our marketplace, and in most marketplaces in the U.S.," Baron says, "if you try to charge patients supplemental fees, you're on the edge of violating agreements with insurance companies." He echoes the call for reimbursement reform. Instead of paying primary care doctors per visit, he says, pay them a preset amount per patient per year, an approach called "capitation" that's used by HMOs.

Although some primary care doctors, worried about inadequate payments, regard capitation as a dirty word, Baron says it "can work just fine if it's based on an accurate understanding of the volume of services a group of patients is going to need."

Besides freeing doctors to provide care in the most efficient way, capitation would enable them to hire support staff, such as medical assistants, says Baron, chairman last year of the American Board of Internal Medicine.

"We don't ask surgeons to stop in the middle of an operation and go find a scalpel," he says. "We arrange it so that there's a skilled team of people that are supported by the reimbursement system."

Baron and Thomas Bodenheimer at the University of California-San Francisco use a phrase that's kicked around a lot these days: "Work up to the top of your license." Translated: Doctors shouldn't waste their time on tasks that could be handled by someone with less training.

"Physicians do a huge amount of work that you do not need an M.D. to do," Bodenheimer says. "There's so much stuff that's routine, you could teach a high school student to do some of these things in a week."

Doctors usually don't hire someone to do that work, Bodenheimer says, because "you can't keep hiring people who don't get reimbursed." He says physicians might find that hiring medical assistants, who typically have one or two years of training after high school, increases efficiency and saves them money, although no one has studied that issue.

Harvard Vanguard Medical Associates, a nonprofit multispecialty group practice that cares for nearly a half-million people in eastern Massachusetts, may have hit upon a way to have its medical assistants — as well as nurses, social workers and dietitians — and pay for them, too.

Shared appointments

In 2008, Harvard Vanguard began offering "shared medical appointments," or SMAs. They're not classes, emphasizes internist Gretchen Gaida.

SMAs are scheduled for physicals, well-child checkups, chronic illness management and other types of primary care, as well as for specialty care. Six to 14 patients, who sign agreements to keep information about the others confidential, participate. SMAs last 1½ hours, but patients can leave when they feel their questions have been answered. Doctors take blood pressures and listen to hearts in front of the room but examine patients in a private room when necessary.

Physicians bill the same for patients seen in an SMA or individually. Considering doctors might schedule only four individual patient visits in 90 minutes, Gaida says, income from SMAs enables Harvard Vanguard to pay for the extra health professionals needed to run them smoothly.

Instead of thumbing through magazines in the waiting room, SMA patients meet in a conference room, where a "behaviorist," a nurse, social worker or psychologist who serves as a facilitator, writes down their questions for the doctor.

"The hardest part is getting patients to try it," says Gaida, who offers three SMAs for physicals each month in Chelmsford. But once they do, she says, 80% to 90% return for another.

Deborah Phillips, 57, of Billerica, Mass., is a convert. "I felt so comfortable, every time I go now that's what I do," says Phillips, who has diabetes. "You'll hear how someone else is handling the same problem that you have, only differently. I don't feel so alone out there."

Many in the health care field look to nurse practitioners and physician assistants, or PAs, to help fill the primary care gap. Both types of providers require graduate-level training.

"There is so much work that physicians do that they could be unburdened of," says Perri Morgan, director of PA research at Duke University.

Eugene Stead, then Duke's chair of medicine, founded the physician assistant profession in the 1960s to train former Vietnam medics to help fill a shortage of primary care doctors, Morgan says.

Today, PA classes are 70% to 80% women, she says, and, while the profession is growing, the proportion opting to practice in primary care has declined, while an increasing number are following physicians into specialties.

"We should just make more PAs," says Morgan, who wrote about the move away from primary care in May in the journal *Health Affairs*. "We can make PAs so much faster than doctors. There aren't going to be enough doctors anyway. And I'd like to see a larger proportion going into primary care."

Unlike nurse practitioners, PAs can't work independently of doctors anywhere, Morgan says.

"PAs are committed to being dependent practitioners," she says. Still, some practice fairly autonomously, she says, and don't consult doctor supervisors every day.

In the past 18 months, many states have begun to re-examine laws governing what nurse practitioners can do, says nurse practitioner Mary Naylor,

a University of Pennsylvania gerontology professor. Currently, Naylor says, the most restrictive states don't allow nurse practitioners to prescribe medication or practice without a doctor's supervision.

Nurse-managed centers

Donna Torrisi, a member of Penn's second graduating class of nurse practitioners in 1976, was instrumental in persuading Pennsylvania legislators to grant nurse practitioners prescribing authority and recognition as primary care providers. In 1992, she helped found the Family Practice and Counseling Network in Philadelphia, which she still directs.

Supported by the non-profit Resources for Human Development, the network of nurse-managed centers offers primary care for all ages, serving public housing residents, the poor and the uninsured.

This past fiscal year, Torrisi says, the network's three sites racked up 60,000 patient visits; this year, it expects 70,000. As a federally qualified health center, the network is reimbursed on the basis of its costs, not the number of patient visits.

On a sunny spring day in the network's sprawling, tastefully decorated North Philadelphia center, Torrisi, who sees patients one day a week, stopped to chat with patient Irene Pegram. Pegram, 76, clutched a paper bag of medication and worked on word puzzles while she waited for a ride home. A network patient for 16 years, she was diagnosed with diabetes five years ago. "Right now I'm coming in every week for the diabetes class," she says.

In the class, a nurse trained as a diabetic health educator sat at a table with eight patients. They played a board game that provided tips on managing their disease. Elsewhere at the center, a social worker led a "Stress Less" class, which utilizes such stress-relievers as yoga and essential oils, while a recovering addict, hired 17 years ago, led a support group for people battling their own addictions.

While nurses rule at Torrisi's clinics, "you need everybody" to meet the need for primary care, she says. "You need the doctors. You need the physician assistants, you need the nurse practitioners."