

Review & Commentary on Health Policy Issues for a Rural Perspective – October 1st, 2012

A Rural Need to Know about New Medicare

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative, Sauk City

I love my digital video recorder, during election season more than ever. It is great to record favorite shows for watching whenever you want to. And it preserves my aging sanity to be able to click forward over the endless televised political tantrums.

Like many of us in Wisconsin, I'm tired of the endless candidate robocalls. Call me stupid, but I really don't think Republicans will send granny (my wife) over the cliff or that the Democrats will put her before a "death panel."

The real differences between the parties are significant. But both share the reality that Medicare is going broke and needs to be reformed. The question is how to do it?

"The Obama approach is to stay with government-provided traditional Medicare while putting pressure on health care providers to deliver care more efficiently, and instituting new payment models and coordination of care to cut costs. The Romney-Ryan plan turns to competition among insurance companies to lower costs and premium-support payments to induce seniors to pick their health plans based on price." (FactCheck.org, 8/22/12)

This may be an election in which we get to pick our poison: health care run by big government or by big business. As an optimist, I believe Medicare over time will not stray too far from its American roots—taking care of our seniors while maintaining a healthy tension between the public sector and the marketplace.

But a lot of specifics are missing in action. I need to know what will the *new* Medicare do to rural Medicare beneficiaries, rural communities and the health care providers that serve them? For me, the following questions apply equally to both parties. **Will a new Medicare...**



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... protect or undermine rural beneficiaries getting healthcare locally?

... make it harder for the rest of the rural community to receive care locally?

... encourage insurers and providers to serve all rural patients, including the least healthy?

... support the unique role of rural hospitals and rural clinics?

... increase or decrease the jobs available in rural America?

Like many of us who live and/or work in rural America, I am sick of being treated as if we are a drag on the Medicare program. Some would want you to believe that rural is a black hole for scarce Medicare dollars.

In fact, the opposite is true according to a new report by iVantage Health Analytics: “Physician services payments are 18% lower and Hospital service payments are 2% lower for Medicare beneficiaries living in rural versus non-rural settings. Cost per Medicare beneficiary is 3.7% lower overall for rural beneficiaries.”

“Approximately \$7.2 billion in annual savings to the Medicare program could be realized if the average cost per urban beneficiary were equal to the average cost per rural beneficiary. Medicare already benefits from \$2.2 billion of lower beneficiary costs for care delivered to rural beneficiaries vs. urban.”

Rural citizens pay taxes at the same rate as all Americans. Some may wish to have rural pay more to receive less than the rest of the country. But there is no basis for saying that rural is receiving more than its fair share of Medicare spending.

Regardless of who wins this election, those of us in rural healthcare must be part of the solution. To be part of saving Medicare, rural healthcare providers, like all providers, need to continue doing more, better for less.

We need to make the full transition to adopt health information technology. We need to focus on providing quality and cost effective care as opposed to simply the volume of service. We need to collaborate with each other and urban providers to deliver

Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC 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.

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the continuum of care seamlessly to all patients. We need to partner with all parts of our rural communities to create a healthier people.

Bottom line: rural America is affected by where our health care dollars are spent; rural communities are hurt badly when policy and politics ignore the impact on rural health and the impact on the local rural economy.

Rural Boomers Feeling Physician Crunch

From “Boomers retiring to rural areas won’t find doctors” by Associated Press, 9/3/12:

“Nina Musselman had no trouble finding a family doctor when she retired to rural Oregon nine years ago to be closer to her children. But then that doctor moved away, leaving her to search for another who would take Medicare. After a year of going from doctor to doctor, she finally found one who stuck.”

“As record numbers of baby boomers go into retirement, many are thinking about moving from the places they needed to live to make a living, and going someplace warmer, quieter or prettier.”

“If they choose small towns like Grants Pass, 250 miles south of Portland, they could well have a hard time finding a family doctor willing to take Medicare, even supplemental plans, rather than private insurance. ‘It’s a sad situation for seniors,’ she said.”

“There are several reasons boomers, the 78 million Americans born between 1946 and 1964, could face difficulties finding a doctor if they retire to small towns over the next 20 years.”

“Many primary care doctors prefer to live and work in urban areas because of greater cultural opportunities, better schools and job opportunities for spouses.”

“Also, Medicare pays rural doctors less per procedure than urban physicians because their operating costs are supposedly less. That makes rural doctors less likely to accept Medicare patients.”

“With cuts to Medicare reimbursement for doctors targeted under the federal health care overhaul, the shortage is likely to get even worse, said Mark Pauly, professor of health care management at the University of Pennsylvania.”



“That is, unless increasing reimbursements for nurse practitioners and physicians’ assistants encourages those providers to take up the slack, Pauly said.”

“If the Medicare cuts go through, ‘the doctors are saying: ‘We’re out of here,’ Pauly said. ‘The least they are saying is: ‘We’ll treat Medicare patients like we treat Medicaid patients,’ which is mostly not.’ ”

“Nationwide, the 22.5 percent of primary care doctors who practice in rural areas roughly matches the 24 percent of Medicare patients living there, said Dr. Roland Goertz, chairman of the American Academy of Family Physicians board.”

“A survey of academy members nationwide shows 83 percent take new Medicare patients. But there is an overall shortage of primary care physicians that still makes it hard for retirees to find a family doctor.”

“The real problem, he said, is that the health care system ‘has not supported a robust, adequate primary care workforce for over 30 years.’ ”

“According to the American Association of Medical Colleges, rural areas need about 20,000 primary care doctors to make up for the shortages, but only about 16,500 medical doctors and 3,500 doctors of osteopathy graduate yearly.”

“ ‘We are always trying to recruit doctors. We are barely keeping even,’ said Lyle Jackson, the medical director at the Mid-Rogue Independent Physician Association, a cooperative of doctors in Josephine County, where Musselman lives.”

“A 2009 survey of doctors in the Oregon Medical Association showed concern over Medicare reimbursement rates topping the list of 23 issues, with 79 percent rating it as very important, said Joy Conklin, an official at the association.”

“The survey showed 19.1 percent of Oregon doctors had closed their practices to Medicare, and 28.1 percent had restricted the numbers of Medicare patients. That really becomes evident in Josephine County. Low taxes, cheap housing, wineries, a symphony and low traffic put it in top 10 lists for retirement communities. The 2010 census puts the number of people older than 65 at 23 percent, compared to 14 percent for the state.”

“But the County Health Rankings & Roadmaps website <<http://ow.ly/dvv2Q>>, which gathers a range of health care data nationwide, shows 933 patients for every primary care physician in the county, nearly 50 percent higher than the national 631-to-one rate.”

“At the Grants Pass Clinic, Dr. Bruce Stowell said they are no longer taking new Medicare patients. Medicare pays about 45 percent of what commercial insurance pays. As it is, their proportion of Medicare patients is double that of a similar Portland practice.”

“Dr. Atul Grover, chief of public policy for the American Association of Medical Colleges, said the nation is facing a tough time recruiting for primary care as well as other specialties that treat Medicare patients, such as oncologists.”

“When he decided to become a primary care doctor in the 1990s, it was because of a widespread belief that health maintenance organizations were going to be hiring all the doctors.”

“He said they wanted primary care doctors to emphasize wellness and prevention. Now, many graduates are moving into specialties that do procedures, such as surgery, because Medicare pays more for them than plain-old office visits.”

“Also, the Balanced Budget Act of 1997 capped the number of residencies paid by Medicare, so there is no quick way to increase the numbers of doctors in general, let alone in rural areas, he said.”

“ ‘An entire year’s worth of doctor production is needed to deal with the (rural-area) shortage just today,’ he said.”

The Federal Kink In Physician Pipeline

From “Doctor Shortage May Swell to 130,000 With Cap” by Alex Wayne in the *Bloomberg News*, 8/29/12:

“With a shortage of doctors in the U.S., American medical schools are struggling to close the gap.”

“One major reason: **The residency programs to train new doctors are largely paid for by the federal government, and the number of students accepted into such programs has been capped at the same level for 15 years.** Medical schools are holding back on further expansion because the number of applicants for residencies already exceeds the available positions, according to the National Resident Matching Program, a 60-year-old Washington-based nonprofit that oversees the program.”

“**The bottleneck will likely affect efforts at health-care reform, spreading doctor shortages that now largely affect rural communities to all parts of the country in the next decade.** Patients will probably have to wait to see doctors if they can find room at all, undermining the prospect of cutting health costs through more preventative care. ‘The training programs know that they are not now able to train the numbers of physicians that are going to be needed,’ said Tom Price, a Republican congressman from Georgia. ‘We need to be proactive on this as opposed to reactive. We’re actually already later than we should be in addressing the issue.’ ”

Training Costs—“The cost of training one new resident, meanwhile, has grown to about \$145,000 a year, said Atul Grover, chief public policy officer for the Association of American Medical Colleges. There’s no easy solution. Boosting the number of taxpayer-financed training slots beyond 85,000 would require

Congress to allocate money at a time of contentious budget debates. Adding private financing means tapping new sources of cash, such as from health insurers. Importing doctors from overseas is controversial. And training doctors is long-term work, taking as many as 10 years.”

“Teaching hospitals quadrupled their lobbying budget last year to \$2.8 million, according to the nonprofit Center for Responsive Politics in Washington. They support bipartisan legislation introduced this month that would add 3,000 residencies a year through 2017 at a cost to taxpayers of about \$9 billion. Deficit-watching Republicans, including Price, say private funding needs to be identified instead.”



Fundamental Reform — ‘The problem is the structure of the program is no longer adequate,’ said Price, who is also an orthopedic surgeon, in a telephone interview. ‘What we need I believe is fundamental reform of the funding stream.’ The influx of as many as 30 million new patients into medical offices starting in 16 months with the health-care law is igniting the debate over training doctors. Medicare now funds more than 75 percent of doctor residencies, a level capped by Congress in 1997.”

“Medical students must undergo a residency at a teaching hospital of three to seven years, depending on their specialty, according to the American Medical Association. During this time, they train under the supervision of other doctors as a prerequisite to board testing that certifies them to practice on their own.”

Pressured Fees—“Those residencies are paid for using fees from clinical services that are increasingly under pressure. Federal Medicare payments have been cut while hard-pressed states, facing deficits of their own, have been trimming reimbursements for Medicaid. With private insurers following suit there will not be the clinical revenue to invest in additional slots.”

“Representatives Allyson Schwartz of Pennsylvania, a Democrat, and Aaron Schock of Illinois, a Republican, are co-sponsoring the legislation to increase the residency cap. ‘It is an expense that is necessary,’ Schwartz said in an interview. ‘We’ve seen an increase in the number of doctors that medical schools are training in this country. There’s not an adequate number of residencies’ to handle that increase.”

America’s Forgotten Healthcare Workforce

From “New ad campaign portrays caregivers’ call for help” By Lauran Neergaard in the *Associated Press*, 8/15/12:

“A woman grips her car’s steering wheel and silently lets out a scream as her frail father, on oxygen, coughs beside her and her kids play around in the back seat.”

“The frustration portrayed in an arresting new public service announcement is recognizable to millions of Americans who struggle to care for aging loved ones while holding down jobs, raising children and taking care of their own health.”

“ ‘I take care of her, but who takes care of me?’ says another one of the public service announcements from the nonprofit Ad Council, which is distributing the ads for TV, radio, print and online use. It’s part of a major campaign from AARP and the Ad Council to raise awareness of the impact of family caregiving as the nation rapidly grays—and to point overwhelmed families toward resources that may ease the strain.”

“ ‘Most caregivers don’t know where to turn for help,’ said AARP vice president Debra Whitman, whose own family has experienced caregiving twice, for her grandmother and her mother-in-law.”

“Even knowing what to ask can be a hurdle. That’s what Andrea Phillips of Alexandria, Va., discovered when her mother, now 74, visited from Chicago a few years ago and got too sick to go home. She recovered from a heart problem only to be diagnosed with early Alzheimer’s.”

“Phillips, a lawyer with 1- and 4-year-old daughters, raced to find nearby senior housing that her mother would accept and could afford. But already she’s having to cobble together additional care as the Alzheimer’s worsens. She says her mother skips her pre-paid meals in favor of a cookie stash, misses medication despite Phillips’ daily take-your-pills phone calls and is embarrassed to find herself struggling to remember and perform personal hygiene—the kind of day-to-day issues that health providers didn’t address.”

“ ‘I do constantly feel that I’m playing catch-up,’ said Phillips, adding that she feels guilty when she gets frustrated. ‘I’m trying to find the right resources so Mom and I can continue to have a good relationship.’ ”

“Although they often don’t identify themselves as ‘caregivers,’ more than 42 million Americans perform some form of consistent care for older or impaired adult relatives or friends, according to a 2009 estimate. It can range from paying bills, to driving Mom to doctor appointments, to more hands-on care such as bathing, and even tasks once left to nurses such as the care of open wounds.”

“ ‘At first you’re just helping out Mom. Then it can become more than a fulltime job,’ said AARP’s Whitman.”

“She described the average U.S. caregiver as a 49-year-old woman who on top of her regular job provides nearly 20 hours a week of unpaid care to her mother for nearly five years.”

“An AARP report found family members provide a staggering \$450 billion worth of unpaid care annually—and other research makes clear that the stress and the time involved can take a toll on the caregivers’ own health and finances as they put off their own doctor visits, dip into their savings and cut back their working hours.”

“A key message of the new campaign is for caregivers not to neglect their own needs. The ads direct people to AARP’s website <www.aarp.org/caregiving> to find information and services from that organization and others, what Whitman describes as a one-stop starting point for resources. The site offers Web chats with

caregiving experts, online support groups, legal documents and links to such programs as locators for care providers <www.eldercare.gov> or links to respite service programs <www.archrespice.org>. A new 'Prepare to Care' brochure offers to-do checklists for families new to caregiving, and people not as web-savvy can call a hotline at 877-333-5885."

"Too many caregivers don't know such services exist, or even that they can ask their loved ones' doctors to refer them for help until there's a crisis, said Dr. Eileen Callahan, a geriatrician at New York's Mount Sinai Medical Center who isn't involved with the AARP campaign."

"The AARP project is broader than another new effort targeting caregivers—a government website that, as part of the National Alzheimer's Plan, offers families information specific to dementia care at <www.alzheimers.gov>."



mined whether the presence of protective or risk factors differ between youth in rural and urban areas."

"Using data from the CDC's 2008-2009 National Survey of Drug Use and Health, this study examines the factors associated with adolescent alcohol use, comparing rural and urban populations, and the extent to which differences between the two populations account for rural-urban variations in adolescent

alcohol use. This knowledge is crucial to the development of rural-specific prevention strategies, targeted research on rural adolescent alcohol use, and long-term policy approaches. Rural and urban areas are identified based on the Office Management and Budget metropolitan and nonmetropolitan county designations. For this study, we conducted bivariate and multivariate analyses of the prevalence of alcohol use and abuse across rural and urban areas and the relationships between alcohol use and potential protective or risk factors including parent relations, peer relations, school relations, and religious involvement."

Findings—"Rural adolescents are more likely to engage in binge drinking and driving under the influence than urban adolescents." In analyzing patterns of youth drinking by age group, we observed higher rates of past year alcohol use among rural than urban 12-13 year olds. Evidence indicates that a lower age of first use is associated with an increased risk of problem drinking behaviors and alcohol use disorders in later adolescence and adulthood. Higher rates of drinking among the youngest adolescents may partially explain rural-urban variations in binge drinking and driving under the influence."

"Adolescents are less likely to binge drink when selected protective factors (including parent disapproval of drinking, parent help with homework, youth likes school, youth disapproves of peers drinking alcohol, friends disapprove of youth drinking alcohol, and religious beliefs influence life decisions) are present. Many of these factors are less common among rural youth, e.g. parents disapprove of drinking and friends

Rural Kids: Higher Risk Binge Drinking & DUI

From "Adolescent Alcohol Use: Do Risk and Protective Factors Explain Rural-Urban Differences?" by John Gale, Jennifer Lenardson, David Lambert and David Hartley in the *Maine Rural Health Research Center Policy Brief*, 3/12:

Overview—"Adolescent alcohol use is a significant public health problem among U.S. adolescents, with 26% of 12-17 year-olds reporting past month drinking in 2010. During the month preceding the 2009 Youth Risk Behavior Survey, 42% of high school students drank alcohol, 24% engaged in binge drinking, 10% drove after drinking, and 28% rode in a car with a driver who had been drinking. Past studies have found that rural adolescents were more likely to use alcohol than urban adolescents. Research has not yet deter-

disapprove of drinking; while others are more common among rural youth, e.g. parents help with homework and religious beliefs influence life's decisions. However, rural residence is associated with increased odds of binge drinking and driving under the influence even when these factors are taken into account."

Policy Implications—"Rural adolescent alcohol use is a complex social problem. **After controlling for a broad range of key risk and preventive factors, it is clear that an unexplained rural effect persists. Although we are unable to explain fully the cause of higher rural adolescent drinking, we identify rural differences in a number of risk and protective factors that, when viewed together, may help to account for a portion of the differences in rural adolescent alcohol use and suggest opportunities for intervention.** Given the multiple protective and risk factors at work in rural areas and higher rates of drinking among very young rural adolescents, our research suggests that prevention strategies should target pre-teens and younger adolescents and directly involve parents, peers, schools and churches. Our research also suggests that multiple intervention strategies with consistent messages should target different community organizations and populations."

Links to several interventions are provided in the full-length report, available at <<http://ow.ly/dtU6x>>.

The Roadmaps to Health Action Center at the University of Wisconsin also provides tools to address this and other health issues at <<http://ow.ly/dtXvZ>>.

Leadership Insights: "Inviting Feedback"

The following is from the August issue of RWHC's *Leadership Insights* newsletter by Jo Anne Preston. Back issues are available at:

www.RWHC.com/News/RWHCLeadershipNewsletter.aspx

"I wonder who the president trusts to tell him he's not coming across well (besides his critics who he might dismiss as just not being 'for' him). I suppose the spouse, or a paid consultant, might be willing to say,

'That speech? It was really off the mark.' As a leader, whether front line manager or CEO, it can enhance your performance to receive **candid feedback** about how you are coming across. Perception is everything, and other people's perceptions can surprise us sometimes. We're generally better off knowing so that we can address our own shortcomings."

"Imagine being told that you:

- Exhibit behaviors that undermine the organization's established meeting ground rules (you arrive late to meetings, take phone calls or text during meetings, have side conversations, etc.)
- Make statements about a high standard for customer service but neglect to greet staff in the hall
- Announce an open door policy, "*Come see me anytime with questions,*" but are rarely available
- Request input, but when others have shared their concerns or disagreements, it has left you acting defensive or irritated with that employee
- Promote direct 'A to B' communication, then are heard making negative comments about staff who are not present
- Have habits like eye rolling or interrupting"

"Often we are not even aware when we are doing these things, but leaders are carefully observed by staff. Little things get noticed—both good and bad—and leaders can underestimate the extent of the influence their behaviors have on others."

"Giving difficult feedback up the chain of command is particularly intimidating. There is a lot at stake for staff to take this risk. Consider choosing from the approaches below that feel more comfortable to you to encourage staff to give you feedback. Whatever your personality style, the goal is to make sure people sense that you are accessible."

- **"Ask for feedback.** Formally through survey processes, but more importantly, informally, such as after a meeting you have led. Ask for staff to tell you one thing that you did well and one thing that

could be done better next time. People notice and interpret your behaviors and words through their own filters. Only open dialogue can clarify these interpretations.”

- **“Openly announce *your* intent.** Sometimes feedback conversations go badly when you feel threatened by what you think the *other person intends*, i.e. thinking that the employee intends to cause you trouble, or they just don’t like you. Announce that your intent in seeking feedback is to simply grow as a leader, to be the best leader you can be. Then **assume good intent** on the part of the employee.”
- **“THANK THEM.** If someone does take the risk to give you feedback, THANK THEM and resist the urge to explain away behaviors or justify your actions. You may well have a good reason for the behaviors that others are misinterpreting, but **listen first** for what you can learn. For example, if you must stay online during meetings, rather than defend your reasons to the person giving you feedback, consider what you can learn from it, and that you may want to approach this behavior differently in the future. For example, you may decide to announce at the beginning of a meeting that you will

need to be online during the meeting for a particular purpose. This way you acknowledge ground rules up front and your honest communication removes conjecture on the part of others about what you might be Googling.”

- **“Go out of your way to try a behavior change** for which you have received feedback. Imagine you have an employee who takes the risk to share with you that you seem to spend more time interacting with favored groups or individuals in the organization, and they feel overlooked. Chances are very good that you weren’t aware of doing anything that looked like favoritism. Ramp up MBWA: *management by walking around*. Go out of your way to connect with employee groups not in your area of the building, and engage staff you do not know very well in conversation about their work or their hobbies.”

Contact Jo Anne Preston for individual or group coaching at jpreston@rwhc.com or 608-644-3261. For Info re the RWHC Leadership Series 2011-2012 go to www.rwhc.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@rwhc.com or 608-643-2343.”

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