

Review & Commentary on Health Policy Issues for a Rural Perspective – February, 2009

Workforce Crisis – “Time for Talk is Over”

From “HRSA Moves to Head Off Health Care Workforce Shortage” from *Inside HRSA*, US Department of Health and Human Services, Health Resources and Services Administration, 1/09:

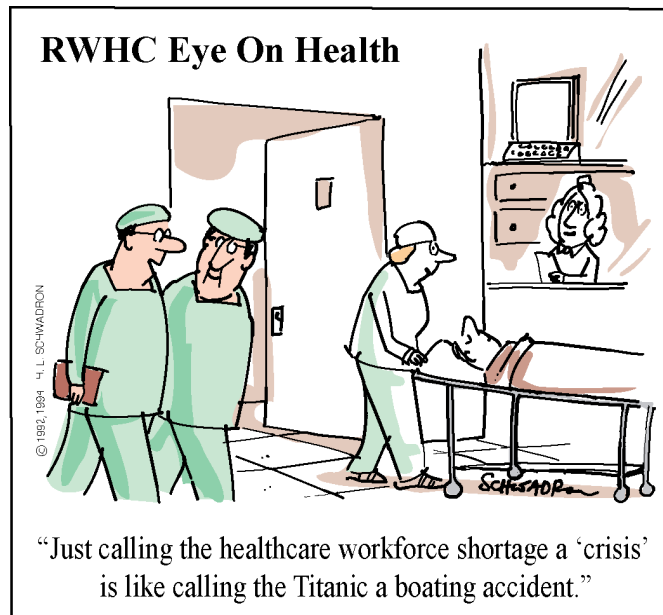
“ ‘There are shortages in primary care, everywhere,’ confirmed Associate Administrator Marcia Brand of the Bureau of Health Professions, ‘and they are growing. We think it’s not too late for primary care medicine, but there are a lot of folks out there who say it is...that we won’t be able to turn this around in time.’ ”

“ ‘It’s the number one issue for the 1,200 HRSA-supported health centers across the country and the 8,000 physicians who work in them,’ said Jim Macrae, associate administrator for the Bureau of Primary Health Care. ‘Especially if you’re the only provider in a remote community, or one of only two or three in a practice, you’re being asked to do it all. They’re getting more and more pressure...with no new staff.’ ”

“At HRSA’s Bureau of Clinician Recruitment and Service, Associate Administrator Rick Smith said the workforce numbers have steadily ‘tipped in the wrong direction’ over the past 10 years—driven by demographic forces that challenge long-held aca-

demographic assumptions about how many doctors, nurses and dentists the nation would need.”

“For decades, forecasts of the future healthcare workforce requirements of the country had been notoriously inconsistent, and often wrong, hampered by a variety of factors: **poor data collection by state licensure boards**; long lag times between Census counts; and the general availability of foreign-trained healthcare workers eager to accept visas to fill localized shortages.”



“ ‘Now, we are talking about 47-49 million people in the categories of medically underserved, or unserved,’ Smith said, ‘people who are almost completely without access to routine health care.’ ”

“ ‘Now, figure in the downstream consequences of the current economy: More people losing their jobs, losing their health care coverage along with access to preventative care. To that, add the thousands

of returning veterans who are going to need unique health services, plus their families; and, of course, millions of aging Baby Boomers.’ ”

“Then, when you turn and look at the pipeline of students who are currently in medical schools, nursing programs, dental programs—and the ones who are in the waiting line behind them for admission—it’s nowhere near enough to meet current demand, much less the surge that’s coming.”

“For Smith, and his counterparts in HRSA’s workforce-centered bureaus, the scenario represents a ‘perfect storm.’ ”

“ ‘For all of the concern about physician shortages, and there is serious cause for concern there,’ said Brand, ‘we are looking at a clear and present crisis in nursing. We have 98,000 people per year in this country dying because of medical errors, and the people we count on most to prevent those errors are the nurses on the ward with their hands on the patient charts.’ ”

“ ‘But a million-nurse shortage is not going to be made up in any kind of near-term timeframe,’ she said. ‘It’s not as simple as flipping a switch,’ Smith added.”

“Here’s why: **Government-sponsored scholarship, student loan and academic debt repayment programs designed to encourage students to pursue careers in medicine and nursing have shrunk in recent decades.**”

“Last year, 14,000 students applied to HRSA for financial assistance, for example, but the agency was only budgeted to grant one of every 7 requests. The shortfall was worst in nursing programs, where the agency received 9,000 applications for 600 available slots, a ratio of 15 to 1.”

“ ‘There are 200 health disciplines in which we know we have shortages,’ Brand said. ‘But we have not begun to quantify dozens of others in which women

have traditionally been the backbone of the workforce—like dietitians, physical therapists, dental assistants, certain lab specialties. We’d be naive to think, given what we’ve seen in nursing, that the current generation of women isn’t feeling the same pressure to move on, or to avoid those occupations in the first place.’ ”

“With the conflicting workforce data on hand—or lack of data—through this period, funding for healthcare career development programs dwindled, leading colleges and universities to downsize (or close) their schools of medicine, dentistry and nursing. At the same time, shrunken faculties were rapidly aging.”

“According to Smith: ‘By the time anyone realized we were headed for the rocks, there were fewer programs, smaller faculties and less overall capacity to produce (clinicians and nurses) in large numbers if we ever needed them.’ ”

“The result: an admissions log jam as students confront long waiting lists to get into medical, dental and nursing schools. In short, graduations are not keeping pace with retirements across many medical professions.”

“The average age of a practicing nurse, 46.8 years old, is now at its highest level since HRSA first began keeping data on the profession in 1980.”

“ ‘Further, when you consider that upwards of a third of the workforce in many medical specialties is now over 50 years of age, you can see that time is not on our side,’ said Betty Duke, HRSA Administrator, in a speech last July in Phoenix to academic counselors, deans and professors. ‘Our workforce is getting hit at both ends.’ ”

“Tom Morris, associate administrator for the Office of Rural Health Policy, summed up the current dilemma this way: ‘We know there’s a large cohort of doctors and nurses who are headed for retirement—and that includes our university professors—and we know we don’t have the people in the pipeline to replace them. Any effort to reform health care can’t go forward without talking about this problem first.’ ”

“Mary Wakefield, associate dean of the School of Medicine at the University of North Dakota—a state in

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.

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which starting salary and benefits packages for graduating general physicians can exceed \$150,000—said the workforce shortages have accentuated a ruthless competitive pecking order in healthcare.”

“At the top, big city medical centers and private plan providers are able to offer the highest salaries and most attractive living arrangements for young doctors, dentists, nurses and their families.”

“In the middle of the marketplace, Wakefield said, a wide range of government-supported providers—federal and state prison systems, the Veterans’ Administration, the health centers—often have an edge in recruiting young professionals because of their relative proximity to attractive suburban communities, high-performing schools and the cultural amenities of downtown life.”

“At the bottom, however, are hundreds of rural enclaves, agricultural communities and Native American reservations that lack the population bases, local economies, or countervailing lifestyle benefits to attract and maintain their own healthcare providers.”

“Approximately 20 percent of the U.S. population lives in rural areas, spread out over 80 percent of the nation’s land mass, Morris reminds his counterparts.”

“‘If urban areas are having their issues with workforce recruitment,’ Wakefield warned, ‘that absolutely impacts the rural areas and patient care in those communities,’ which already are at a competitive disadvantage.”

“Hilda Heady, an associate vice president for rural health at West Virginia University, added that there other unforeseen pitfalls working against rural communities as they struggle to hold onto primary care practitioners.”

“ ‘One of the things that’s happening now is that we are finding that our health centers are losing primary care doctors and dentists to the federal prison system, which has been moving into rural areas, or to the VA, which is doing more rural outreach,’ Heady said.”

“ ‘These are federal dollars that are supporting the workforce for all of these agencies, but the pay scales are different and the benefits

are different. So it’s out of balance. It turns into musical doctors. Just when you get one, they’re getting ready to go away to work for another government entity or private plan provider offering better pay, more generous benefits and greater opportunities for professional advancement.”

“ ‘We’re competing against ourselves, in more ways than one,’ she said.”

Conversation with Federal Workforce Leader

From “A Conversation with Dr. Marcia Brand” from *Inside HRSA*, US Department of Health and Human Services, Health Resources and Services Administration, 1/09:

RWHC Eye On Health



There has been a sudden rash of media reports about regional workforce shortages in American hospitals, clinics and rural communities. Some are calling it a crisis. Is that going too far?

“I don’t think there’s much question that we’re looking at a crisis scenario, but it really does depend on where you live. One of the big mistakes that experts have made in trying to estimate the workforce supply over the years is that they’ve usually averaged it across the nation. They’ve run

the numbers based on overall physician-to-patient ratios, for example, and concluded, ‘Well, this looks good; we have plenty of doctors, or dentists or nurses.’ ”

“But that really doesn’t tell us much if two-thirds of the clinicians in a given health profession are based in big medical centers in Boston, Philadelphia, Chicago, San Francisco, Denver, and Dallas—while the rest of the country goes without. And even where there appear to be adequate numbers of providers, some folks don’t have access to them because of poverty, lack of health insurance, etc.”

What’s the consequence of our inability to describe the health professions workforce?

“You’re just not getting an accurate picture. We wind up with denial in some places that there’s a problem, while people are crying out that they can’t find a doctor. So there is a lag in recognition that these might be leading indicators—until it’s too late. In the health professions, that’s been the historic pattern. This isn’t the first time this has happened, although it remains to be seen if this is the worst one we’ve faced.”

The average person reading this might say, a shortage of a million nurses by 2025 — or 100,000 doctors — is kind of hard to miss. How did it reach this stage?

“Well, certainly HRSA saw this coming a long time ago. But part of the historic pattern, and it’s a legitimate question, is whether state governments aren’t better situated to mind their own stores—at least in theory—to fund their own university systems and scholarship programs in the health professions.”

“Some state legislatures have done a fairly good job of monitoring their workforces. But other states face much bigger challenges...much tighter budgets. Frankly, the best data available in some regions of the country are largely anecdotal—which is a nice way of saying, there isn’t much hard evidence we can point to.”

So what’s the current best guess?

“When you have 49 million Americans without health care, and 20 states reporting significant health

Rural Hospitals Work to Attract “Home Grown” Care Givers

RWHC has developed templates for a hospital based “grow your own” “Pre-Employee Educational Loan Program.” A “fill in the blanks” loan agreement as well as a draft template of the policy document needed to manage such a loan program is available at no cost for download at www.rwhc.com.

care workforce shortages, it’s not a subtle academic discussion anymore. And none of them, as we’ve seen in recent months, are well-positioned to deal with the huge economic and demographic shifts they’re now facing.”

“Most folks in the health care system understand now that we have a serious problem, because it’s begun to reach into places that have not traditionally been affected by this before. I’m usually the eternal optimist, but in this case I really do believe we’ve waited too long.”

“We need to do something now—right now—to have any hope of turning this around by the time the Baby Boomers hit the system in large numbers.”

A Picture of the Wisconsin Workforce Crisis

From a presentation by Tim Size on behalf of RWHC to the State of Wisconsin’s Injured Patients & Families Compensation Fund, Advisory Committee on Fund Participation, 1/20/09:

The Advisory Committee requested feedback on four questions relevant to the challenges around health care accessibility in rural areas and how health care delivery is evolving in these areas. RWHC Board members as well as many other key in-state informants provide their thoughts.

Q1: Is there a current physician shortage in rural Wisconsin? If so, is the shortage more pronounced in primary care or specialty care?

A1: While more than 20% of Americans live in rural areas, only 9% of physicians practice in rural locations. Nationally, rural America has long struggled with a shortage of physicians and as that shortage spreads to urban areas, the rural

shortage is becoming more intense. Wisconsin faces the same challenge and it is predicted to get a lot worse before it gets better.



Due to the numbers of jobs available, the shortages are mostly in Primary Care (both Family Medicine and Internal Medicine). However, the growing shortage in General Surgery is particularly troubling given their critical role with patients needing emergency interventions. Other needed specialists in Orthopedic Surgery and Obstetrics/Gynecology are also already extremely difficult to recruit successfully.

The October 2008 Report from the Wisconsin Council on Medical Education and Workforce, *Who Will Care For Our Patients?* estimates the future supply and demand of physicians from a number of separate projections for the years 2020 and 2030:

- “Demand is estimated to increase by 9% to 33% by 2020, and 13% to 65% by 2030.
- Supply is projected to increase by 13% by 2020, and 21% by 2030. A separate projection for primary care physicians shows a 5% increase by 2020, and an 8% increase by 2030.
- The most likely scenario shows a small shortfall in 2030 for all physicians, with the worst-case shortfall of 44%. However, for primary care physicians, the most likely scenario predicts shortfalls of 8% by 2020, and 14% by 2030. The worst-case shortfall is 57%.”

Q2: Is there an increase in the use of locum tenens in rural WI? Are these staffing needs being met via contracts with staffing companies and are these companies required to obtain medical malpractice insurance for their physicians? If so, does this include Fund coverage?

A2: There is a trend among rural facilities to move from emergency department coverage by the medical staff on a rotation basis to hiring or contracting physicians for the emergency department (increasing operating costs). In part, this trend is an effort to mitigate some of the chal-

lenges faced by local medical staffs, as noted above. In some cases, locum tenens are being used but this is very expensive and is difficult to sustain.

Q3: Are you seeing rural clinics being staffed by APNPs and PAs with or without a physician on-site?

A3: There is an increase in the utilization of APNPs and PAs in rural communities. This can be expected to further increase as the shortage of primary care providers increases. More APNPs and PAs will be needed to work at locations where there is no physician “on site”. Current and future contributions are respected and needed but Advanced Health Practitioners (AHPs) are generally not seen as a “cure all” for physician shortages given the unique needs of rural practices.

Q4: From your perspective, what are the future health care access, quality and cost issues in rural Wisconsin and what do you foresee as potential solutions or trends toward addressing those issues?

A4: Rural clinicians and providers are frequently in particularly challenging local situations. And like their urban colleagues, they face a future of being increasingly expected to do more with less.

It is clear that Wisconsin will need to make the most effective use of all clinicians that it can train, recruit and retain. On one hand, we need to do all we can to increase the supply of needed clinicians while avoiding supervisory requirements that don’t add value. On the other hand, we need more collaborative practice amongst clinicians as opposed to an explosion of either “doc” or “nurse in box” practices.

Advanced Health Practitioners will have a significant expanded role in helping to address the greater burden of chronic disease among Wisconsin populations over 65. However, the greater preponderance of elderly in rural areas cannot be fully served by AHPs without developing balanced collaboration along the needed continuum of care.

Additional Recommendations

The October 2008 Report from the Wisconsin Council on Medical Education and Workforce, *Who Will Care For Our Patients?* recommends a number of actions to address the expected shortage of health care professionals, in particular primary care providers. Those that relate to rural health include:

- Develop an infrastructure to gather data sufficient to aid in understanding the current and future physician workforce.
- Greatly expand existing tuition reimbursement programs to target primary care physicians and specialists who stay and practice in Wisconsin.
- Lobby Congress to increase the number of Wisconsin residency programs that receive Medicare reimbursement.
- Increase the number of slots at schools producing AHP graduates.
- Break down barriers between medical schools and allied health schools to maximize resources and to eliminate duplicative programs.
- Sponsor or fund research on the medical home model.
- And of course, preserve a favorable malpractice climate in Wisconsin.

Successful Non-Profits Think Node Not Hub

From *The Networked Nonprofit* By Jane Weiskillern and Sonia Marciano Stanford Social Innovation Review Spring 2008; this “must read” article is available at <http://www.ssireview.org/>

“Management wisdom says that nonprofits must be large and in charge to do the most good. But some of the world’s most successful organizations instead stay small, sharing their load with like-minded, long-term partners. The success of these networked nonprofits suggests that organizations should focus less

on growing themselves and more on cultivating their networks.”

“By mobilizing resources outside their immediate control, networked nonprofits achieve their missions far more efficiently, effectively, and sustainably than they could have by working alone. Many traditional nonprofits form short-term partnerships with superficially similar organizations to execute a single program, exchange a few resources, or attract funding. In contrast, networked nonprofits forge long-term partnerships with trusted peers to tackle their missions on multiple fronts. And unlike traditional nonprofit leaders who think of their organizations as hubs and their partners as spokes, networked nonprofit leaders think of their organizations as nodes within a broad constellation that revolves around shared missions and values.”

“Most social issues dwarf even the most well-resourced, well-managed nonprofit. And so it is wrongheaded for nonprofit leaders simply to build their organizations. Instead, they must build capacity outside of their organizations. This requires them to focus on their mission, not their organization; on trust, not control; and on being a node, not a hub.”

“Networked nonprofits are some of the most effective nonprofits in the world. They are different from traditional nonprofits in that they cast their gazes externally rather than internally. They put their mission first and their organization second. They govern through trust rather than control. And they cooperate as equal nodes in a constellation of actors rather than relying on a central hub to command with top-down tactics.”



“By mobilizing vast external resources, networked nonprofits can focus on their own expertise. At the same time, these external resources enhance the value and influence of each organization’s expertise. They help each network partner respond to local needs and become self-sustaining. And they allow networked nonprofits to develop holistic solutions at the scale of the problems they seek to address.”

“Although the social problems that nonprofits are tackling are growing in both magnitude and complexity, funding is failing to keep pace. Networks do not require more resources, but rather a better use of existing resources. And so networked nonprofits are uniquely poised to face the perennial challenge of the nonprofit sector: achieving lofty missions with decidedly humble means.”

Rural ED Performance Improvement

From “Rural Emergency Department Performance Improvement, Introduction to the Series” by Clint MacKinney, MD, MS; Dr. MacKinney is a practicing rural Emergency Department physician and a Stroudwater Associates senior consultant assisting rural hospitals improve Emergency Department performance:

“Emergency care impacts every American. When serious illness or injury strike, Americans of all walks of life count on the nation’s emergency care delivery system to provide timely, accessible, and high-quality care that is available 24 hours a day, 7 days a week. The nation’s Emergency Departments serve a critical role providing emergent and lifesaving care, but they also provide safety net care for the uninsured, public health surveillance, disaster and bioterrorism preparedness, and adjunct care to local physicians.”

“The rural Emergency Department (ED) is critically important to rural communities and their hospitals beyond its safety net role. As required by the Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), the front door of the ED is always open. Community confidence in the rural hospital is highly correlated with rural ED capacities. Rural hospital success and ED performance are also related. On average, over 9% of rural ED patients are admit-

ted to the local hospital or placed on observation. In addition, the volume of ancillary services ordered through the ED is considerable. However, the ED is not simply the front door to the rural hospital and its services. The ED is also the rural hospital’s front window – first and lasting impressions of the hospital are made here. Thus, rural hospital leadership must ensure that ED performance accurately represents the hospital’s commitment to quality, efficiency, and service. Your *attention* to ED performance is the currency of your leadership.”

“This is the first of a series of 10 one-page briefs designed to give rural hospital leaders a quick, easy to-read primer about arguably the most important rural hospital service line – the Emergency Department. Each brief will define an important ED issue, describe the national perspective, and explain why the issue is important in rural America. Lastly, I’ll suggest practical performance improvement tips that you can implement in your rural hospital ED. The series will explore the following topics:

- Financial Stability
- Quality and Safety
- Measuring Performance
- Patient Experience
- Staffing and Governance
- Care Transitions
- Department Design
- Risk Management
- Community Benefit”

Clint plans to email the Rural Emergency Department Performance Improvement briefs periodically. Please contact him to receive the series or with comments or questions at clintmack@cloudnet.com

Local Access to Oncology Services

We regularly showcase a RWHC member 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 story is from the Community Memorial Hospital in Oconto Falls:

“In 2001 Community Memorial Hospital conducted a Community Needs Assessment Survey to determine if there were services that were not being provided in the community if CMH could help meet those needs.”

“From this study, it was determined that oncology services were most pressingly needed in the service area. At the time the nearest oncology treatment area was located in either Marinette or Green Bay. For many people, this meant traveling an hour and a half one way. It was discovered that some people were refusing oncology treatment because of the distance, concern for their physical state when traveling greater distances, and concerns about their insurance.”

“Unfortunately, it was not economically viable for CMH to sustain this service on their own and it would be a financial loss to start this service, even with a partner physician group. However, the organization determined providing this service was vitally important. So, CMH partnered with an oncology physician group to provide an oncology outpatient clinic.”

“Initially these services were provided one day a week. The need for the clinic’s services continued to

grow and the clinic is now available two days a week and will soon be expanded to three days a week. Community Memorial Hospital has continued to expand the availability of the Oncology Outpatient Clinic and enhance this service, despite the financial loss to the organization, because of its importance to the community. The efforts of CMH have been warmly received by the community and the patients. A patient made the following statement one day after her treatment.”

“ ‘I had chemo today, and I just cannot tell you what a wonderful team you have gathered. You can’t buy that kind of caring, passion and compassion. Those core values are in every person there, whether they sign me in, take my vitals and whisper my weight, draw my blood, give me chemo or just stop in and say ‘hi’. I would never want anyone to have to experience cancer and the treatment that follows, but for every unfortunate soul that is handed that journey, I would want them to receive the care and concern I have received in the Oncology Unit at CMH. God bless their hearts.’ ”

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