

Review & Commentary on Health Policy Issues for a Rural Perspective – January 1<sup>st</sup>, 2012

## Physician Shortage: Act Now or Pay Later

by Tim Size, RWHC Executive Director

Wisconsin's rural communities have faced a shortage of physicians for decades. Without changing how we train and retain our next generation of physicians, it is about to get a lot worse. New predictions show future shortages statewide, rural and urban. Urban shortages will only make it even harder to recruit to rural communities.

You can blame people my age—the fabled baby boomers. According to a new report by the Wisconsin Hospital Association (WHA), “100 New Physicians a Year: An Imperative for Wisconsin,” we will be 2,200 doctors short by the time baby boomer retirees finally slow down around the year 2030. Their complete report is available at [www.wha.org](http://www.wha.org)

For the next 20 years, large numbers of older physicians and other health care professionals will be retiring from work and becoming major “consumers” of health care. WHA projects an increase in the number of physicians but not enough to make up for increased demand, increased retirements and the large number of medical school students in Wisconsin that end up practicing elsewhere.

It would be fine to do nothing if this was just about waiting longer for a hot new iPhone or iPad. But

this shortage is a bit more serious. It means many, particularly in rural communities, will wait months to be seen by a doctor. None of us want that wait when we are anxious, have a deteriorating condition or untreated pain.

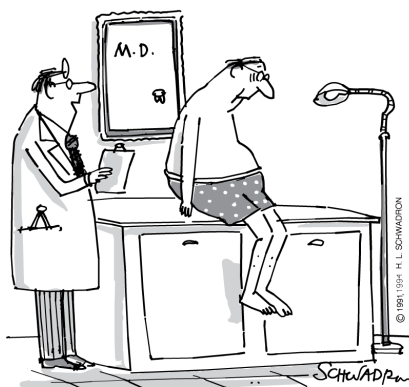
There will also be a significant hit on the rural economy. A retiring rural physician not replaced means a loss of income and jobs throughout the community. Studies at the National Center for Rural Health Works at Oklahoma State University have found that one full-time rural primary care physician generates about \$1.5 million in revenue for the community, and creates, or helps create, 23 jobs.

There are those that say that hospitals and clinics must start doing a better job recruiting physicians into our state. But this is something we are already unusually good at. For every graduate of a Wisconsin medical school, five other physicians are now being recruited from outside Wisconsin. Compared to other states, we are very dependent on “importing” physicians. Other

states face the same impact of aging baby boomers and many will face an even greater increase in demand due to health reform. With that greater competition, we will be very fortunate to maintain our current level of “imports.”

This brings us to the imperative of growing our own. The possibility of our two existing schools expanding the number of students they graduate is encouraging. So is the possibility of the long rumored addition of a new school of osteopathic medicine. But at best, this is only half of the

### RWHC Eye On Health



“If you’re going to worry about dependence on foreign oil, you need to really worry about how few physicians we grow here at home.”

solution. Overall, only 38 percent of the graduates from Wisconsin's two medical schools remain and practice in Wisconsin. We must not only graduate more but also retain them. This requires that we substantially increase the number of in-state and rural residencies—the additional formal training that physicians need after medical school.

If you look at those students who are from Wisconsin, go to medical school here and do their residency here, 86 percent stay and practice in Wisconsin. Bottom line for retaining doctors once they are fully trained: it makes a huge difference where medical schools draw their students from and what they do to encourage their graduates to choose residency training in Wisconsin after graduation.

Our medical schools need to encourage physicians to have their residency experience in rural Wisconsin. This requires rural residencies to be available. We are fortunate to have a nationally recognized Rural Training Track in Baraboo but they can only take two new medical school graduates a year.

The Baraboo residency has now placed over 75% of its graduates in rural practice with over 70% providing rural maternity care and over half of whom have stayed in Wisconsin. These statistics are similar to the other 22 Rural Training Tracks that exist nationally. However, each individual program is small. This

model of education will not make a big impact on the rural access problem without collaborative approaches to expanding the number of these sites. Expanding the number of Rural Training Tracks in Wisconsin must become a top priority.

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## What Will Bundling Do to Rural Health?

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From “Will Bundling Work in Rural America? Analysis of the Feasibility and Consequences of Bundled Payments for Rural Health Providers and Patients” by Robert Town, Walter Gregg, Ira Moscovice, Shailendra Prasad, Jill Klingner at the Upper Midwest Rural Health Research Center at the University of Minnesota, 9/11, available at [www.uppermidwesthrc.org/](http://www.uppermidwesthrc.org/):

“This report assesses how a change in payment structure (i.e. bundling reimbursement payments for acute and post-acute care episodes) may affect existing and emerging relationships between rural and urban-based providers. Under bundled payments, a hospital would receive one payment that would cover inpatient and post-acute care (and, potentially, physician services) for a defined episode of care from admission to a pre-specified number of days post-discharge.”

“The impact of moving to a bundled payment system will depend upon several factors, including the organizational structure and density of providers, the scale and types of services offered by providers, and the population density. Assessing the implications of such a policy change from the perspective of urban communities at the exclusion of consideration of the rural context raises the risk of unintended negative consequences for rural patients and providers.”

“The effective implementation of a bundled payment system faces several challenges. These challenges include: ensuring that hospitals can form the necessary agreements with other providers on how a single payment will be allocated; measuring quality; implementing quality improvement initiatives; and constructing risk-adjusted payments.”

“Implementing bundled payments in *rural* settings raises several additional potential consequences that

**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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need to be addressed. We identify and discuss four potential consequences that could have particular significance for rural providers and rural patients.”

**Finding #1–“Bundled payments may improve the quality of care in rural areas; however, the impact is likely to be unevenly distributed across geography and care systems.** Bundled payments are likely to work best in integrated health care systems, where it is easier to align incentives across providers. Current and past bundled demonstration projects have focused on integrated systems that link predominantly in large, urban-based providers. It is not clear whether the findings of those demonstrations can be generalized to a rural context. Making bundled payments work in non-integrated environments requires addressing these challenges:

- a) Allocating a bundled payment across providers can be a complex and time-consuming negotiation. Allocations can vary according to the bundle of services, the availability of post-acute care (PAC) providers, and the service capacity of the admitting hospital.
- b) Urban referral centers may have an incentive either to directly provide PAC services for discharged rural patients or to contract with other urban providers. In this way, urban referral centers would maintain as much financial and legal control as possible over the efficiency and quality of service delivery.
- c) Contracts among rural providers will likely favor physicians and hospitals over other PAC providers because of the greater bargaining power that physicians and hospitals have related to patient flow and referrals. Thus, other rural PACs (e.g., nursing homes) may see a decline in their net Medicare reimbursements.
- d) Appropriately aligning incentives across providers requires monitoring. The rural environment poses particular challenges for effective monitoring, notably the lack of health information technology (HIT) infrastructure and low levels of competition.”

**Potential Strategies to Address These Issues**–“Based on our assessment of challenges, we suggest that consideration of the following proactive steps:

- Design optimal contractual arrangements that provide rural providers with templates. Such templates would reduce the cost of negotiating contracts across providers and help redress the potential imbalance of provider bargaining power.
- Develop risk- and volume-adjusted performance criteria to facilitate contract monitoring and selection of PAC providers for contracting.
- Provide contract guidance and technical support for small rural providers as they negotiate contracts with larger urban and rural referral centers.
- Design measurement and reporting mechanisms that adapt to both integrated and nonintegrated care delivery models.”

**Finding #2–“Bundled payments may lead to increased provider consolidation and fewer provider options in rural markets.** Since bundled payments are well suited for integrated systems, there will be incentives for rural providers to consolidate vertically and horizontally. For example, a health care system could become owner of a local rural hospital and thus integrate the physicians quickly to create payment and operational efficiencies. In another scenario, a rural hospital could remain independent but have a contractual relationship with a large physician provider group. More of these arrangements are growing now because of the opportunity for provider-based billing.”

#### ***Potential Strategies to Address These Issues***

- “Adjust the criteria for monitoring the anti-trust implications of provider mergers and acquisitions to increase their sensitivity to scale differences found in rural health care markets.
- Assure that rural providers are fully aware of anti-trust enforcement policies regarding service delivery integration.
- Where feasible, require larger hospitals to establish multiple PAC contracts to accommodate consumer choice in health care providers and settings.”

**Finding #3–“Incorporating Critical Access Hospitals (CAHs) into a bundled payment mechanism**

**may not work.** Many CAHs are freestanding facilities; that status further undermines their strength at the bargaining table.”

### ***Potential Strategies to Address This Issue***

- “Exempt CAHs from bundled payments.
- Carve out PAC services provided by CAHs for bundled payments under the same methodology used for PPS providers.
- Create a ‘fixed-bonus’ payment to support the continued operation of CAHs.
- Performance incentives can be incorporated into the bonus payment methodology to encourage service delivery efficiencies and quality.”

**Finding #4—“Under a bundled payment system, safeguards may need to be implemented to protect rural consumer choice and patient-provider relationships.** There is considerable agreement that integrated delivery systems (IDSs) provide a suitable environment for a bundled payment scenario. Such systems also have several options for patient care. Discharged patients could be kept within the corporate umbrella or local contractual relationship of the tertiary care facility in order to achieve greater control over the level of financial and performance risk.”

“The potential loss of access to PACs in a rural patient’s own or nearby community threatens consumers’ ability to choose their care setting. Without sufficient safeguards, patient choice may be lost, support for patient self-management and treatment compliance may be compromised, and the well-being of rural residents could be jeopardized.”

### ***Potential Strategies to Address This Issue***

- “Implement contract requirements that encourage patient choice. One approach would be to document that a specific percent of rural residents discharged from referral hospitals can obtain PAC

services within a reasonable distance from the resident’s home community (e.g., within 30 miles).

- Foster care coordination communication during the transition between hospital discharge and transfer back to the patient’s community. Require transfer communication documentation and reporting.
- Specify a split payment methodology (as with split DRGs) so that each set of providers does not re-create the wheel.”

**Conclusion—**“Implementation of a bundled payment strategy will drive consolidation and regionalization of services both horizontally (e.g., physician groups) and vertically (e.g., hospitals, nursing homes, and home health care). The degree to which this may evolve will depend on a variety of factors, including supply and demand for services, relative levels of competition, the pre-existence of integrated systems of care, and Medicare Conditions of Participation. There is no doubt that providers that are part of an integrated delivery system will encounter a far different experience under bundled payments than independent providers, since the latter must establish con-

tracts with other providers to successfully pursue the same quality and operational performance goals. Rural hospitals, physicians, and other post-acute care providers may elect to remain

independent and seek to establish contractual relationships with other providers in transfer, referral, and treatment efforts, or they may opt for affiliation with or ownership by a larger provider or system.”

**20<sup>th</sup> Annual \$2,500 Monato Essay**

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## **Integrated Care Requires Advanced Broadband**

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From “Advanced Broadband: A Foundation for Care Integration—a white paper by Hospital Sisters Health Systems,” (the whole paper is at [www.rwhc.com](http://www.rwhc.com)):

“In America today, a fragmented healthcare delivery system limits coordination across providers and health care settings and an outdated infrastructure further im-

pedes communication. At Hospital Sisters Health System (HSHS), our Care Integration strategy uses technologies and relationships with advanced broadband to intentionally link patients, providers and care facilities. The result is superior value and improved care coordination, enhanced efficiency with reduced costs, and increased satisfaction for our patients and providers.”

**The Challenge**—“Dense files of medical information cannot be shared in a timely and coherent fashion using low-capacity broadband. Commercially-provided private broadband—often analogous to a narrow two-lane road—cannot accommodate the advanced data exchange needs of hospitals (which are analogous to a multi-lane freeway). Essential applications such as accessing a Picture Archiving and Communications System (PACS) diagnostic file or sharing Electronic Health Records (EHR) require advanced broadband speeds of 100 megabits (Mbps) to one gigabits per second (Gbps). Because these speeds are seldom available at any price (or, if available, are prohibitively expensive), HSHS Care Integration faces many obstacles due to a lack of fiber optic infrastructure.”

**The Solution**—“Distance should never be a barrier to the best possible health care. In medical emergencies, fast and reliable access to health care professionals, health records and diagnostic images—using technology connected by advanced broadband—can be decisive factors that save lives and improve outcomes.”

“Advance broadband networks are foundational to HSHS Care Integration because they remove the distance between caregiver and patient—particularly in rural areas. Not only does advance broadband expand access, it expedites treatment, improves quality and reduces costs through enhanced communication, coordination, and efficiency across provider settings.”

“Advanced broadband allows the whole person to be cared for by a whole health care community throughout the continuum of care settings: hospitals, clinics, physician

#### ***What is Advanced Broadband?***

*Using a highway analogy, broadband is a kind of physical roadway network for sharing digital data.*

- *High-capacity advanced broadband is like a multi-lane freeway and often utilizes fiber optic cable infrastructure to provide speeds of 100 Mbps (megabits per second) to one Gbps (gigabits per second) and beyond.*
- *Lower capacity broadband is analogous to a narrow road and may utilize copper, wireless or satellite technology.*

offices, rehabilitation and skilled nursing facilities, hospice and home. It breaks down barriers by supporting and coordinating patient and provider relationships with a free flow of critical information between providers. Broadband expands relationships to allow organizations to share medical technologies to link patients, providers and care facilities. Its connectivity helps bridge the ‘digital divide’ between urban and rural hospitals and helps caregivers reach vulnerable populations (low income, minorities, older adults, and individuals with disabilities or who need chronic care). The result is improved care coordination, superior value through the elimination of variability, and innovative solutions that can address shortages of health care professionals. Advanced broadband increases patient and provider satisfaction.”

**Broadband Landscape**—“Challenges to broadband Care Integration in Wisconsin: **Wisconsin is among the worst states in the nation in terms of high-speed broadband access with a 2011 ranking of 45th in the nation by the national broadband map.** This

ranking is a significant challenge to HSHS Care Integration, especially since neighboring states provide a vastly better broadband landscape (Michigan is ranked 19th, Minnesota is ranked 28th, and Iowa is ranked 34th). With surrounding states far ahead in their broadband infrastructure connectivity efforts, Wisconsin health care faces greater obstacles to care coordination across providers and health care settings. This reality also adverse-

#### **RWHC Eye On Health**



“Without decent broadband infrastructure, we might as well care for our patients blindfolded.”



ly impacts both the recruitment and retention of needed health care professionals.”

“Because Wisconsin’s telecommunications industry and legislative climate have not encouraged public-private investments in advanced broadband, many Wisconsin hospitals have invested at great cost to create private fiber optic networks. Hospitals have also collaborated with municipalities, schools, colleges, universities, libraries and non-profits to create community area networks (CANs).”

***Hospitals utilize advance broadband for:***

- *Storage of and access to digital imaging modalities including radiology and advanced cardiology studies*
- *Telemedicine and other telepresence links*
- *Shared applications (electronic health records, data backup, telephone, paging, voice mail, etc.)*

***Hospitals Need Broadband that is:***

- *Fast*
- *Accessible—even for rural and critical access hospitals*
- *Reliable—with redundant links to assure mission critical applications are available 24/7 without the risk of downtime that could interrupt applications like telemedicine*
- *Affordable—to bend the cost curve*

free, they perform outreach in the community, and they link with other communities to brainstorm new strategies. Barrier issues are complicated and systemic and usually cannot be fixed by any one entity of the system. However, if different groups work together to combat these access to care barriers, slowly these walls can begin to fall.”

“Yet, there is one glaringly different reason that im-

munization rates are lower in both rural and urban areas: the anti-vaccine movement. Recently, the AP reported in the *Milwaukee Journal Sentinel* that the percentage of school-aged children who are unvaccinated is on the rise. The article cited some general reasons why parents were skipping shots, such as the belief that vaccines do more harm than good and the belief that vaccines are unnecessary. The article (see link below) also suggested that parents were opting to fill out exemption waivers instead of getting shots because this requires less work than actually going to the doctor.”

“While the situation that causes a parent to apply for a personal conviction waiver because they are unable to get to a doctor is undoubtedly a concern, it is part of those systemic, access barriers. The choice, however, to not vaccinate because of a belief that vaccines are harmful or unnecessary is an entirely different issue. The anti-vaccine movement complicates the problem of low vaccination rates, and means that these rates cannot be addressed with the traditional measures that other access to care problems have been addressed.”

“When talking to community members in rural areas of Wisconsin, I learned of the impact one community member can have on a small community. A very vocal opponent of vaccines can garner quite a following in a small community when other voices do not speak up. But loud voices can be combated even in small communities. Communities need to collaborate to discover new ways to get messages out to the well-meaning parents who are only hearing one message.”

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## Communications and Vaccination

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The following commentary is by Kristen Audet, a University of Wisconsin Population Health Service Fellow with a two year placement at RWHC. The Wisconsin Partnership Program for a Healthy Future created the Wisconsin Population Health Service Fellowship Program for the purpose of improving the public health workforce through service learning.

“While working with the Southern Wisconsin Immunization Consortium, I am asked about once a week, ‘So why *are* the rates so much lower in these rural counties?’ That this would be the first question is understandable. However, the answer is not so easily understood. It is easy to name the most apparent access to care barriers that lead to lower immunization rates: fewer providers, farther distances to drive, cost issues, special populations, etc. Further, the uniqueness of each county means that each of these barriers comes with their own distinctive nuances, county by county. The public health community has a good knowledge of many of these nuances, and county health departments work incredibly hard to combat any and all barriers they can. Counties hold extra clinics, they give vaccines for

“Finally, the anti-vaccine movement attracts parents who have their own child’s health at their best interests, which is one reason experts have pointed out the success of the anti-vaccine movement. However, as the *Milwaukee Journal Sentinel* notes, experts such as Dr. Swain have also pointed out that we need a greater emphasis on our *community* health. Vaccines protect a community. We need parents to realize that while they should be concerned about their own child’s health, they must also be concerned with the whole community; in a phrase, it takes a village. For more information see:

- “More Kids Are Missing School Shots,” *Milwaukee Journal Sentinel*, November 29<sup>th</sup>, 2011 at <http://ow.ly/7XCEe>
- “More Kids Skip School Shots in 8 States,” *AP Impact*, November 28<sup>th</sup>: <http://ow.ly/7XCGK>
- “Cultural Perceptions on Vaccination, The History of Vaccines” at <http://ow.ly/7XCI5> ”

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## Attitude Adjustment?

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*The following is from the November Issue of RWHC’s Leadership Insights newsletter by Jo Anne Preston. Back issues are available at:*

[www.RWHC.com/News/RWHCLeadershipNewsletter.aspx](http://www.RWHC.com/News/RWHCLeadershipNewsletter.aspx)

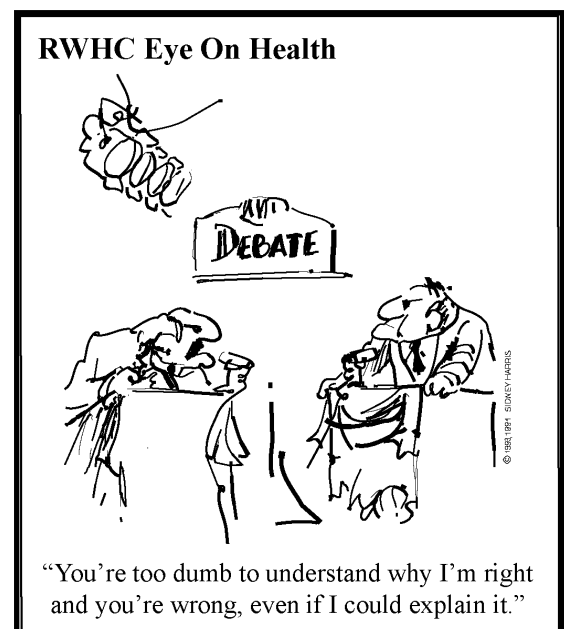
“We know who needs one. When we say, ‘*their attitude is the problem.*’ Most people draw conclusions in their head about what that means and nod in understanding. But if you want to talk to someone about their ‘attitude problem.’ you have to be more **specific** about what concerns you and explain **what you want instead**. If we just coach with, ‘I’d like to see a more positive attitude from you,’ it usually just makes people defensive. It also does not leave the person with clear expectations about going forward.”

“What are the specific things you **hear, see, notice or observe** that lead you to your conclusion that a person has a bad attitude? Usually they will do one or more of these things that we can see or hear:

1. Roll their eyes

2. Slump in their body posture, or turn away from one who is speaking
3. Frown
4. Not greet others, or just mumble a greeting
5. Not look up from their work to acknowledge someone entering a room or common area
6. Sigh audibly
7. Raise their eyebrows at someone else’s comment or behavior but not say anything
8. Speak in a tone of voice that is monotone, loud or puts emphasis on certain words that get your attention
9. Sit in a meeting and stay quiet when asked for input, or work on other things than what the meeting is focused on
10. Holding side conversations during meetings
11. When you ask for volunteers or help, they just look down or away and do not offer to help
12. If they do offer to help, they sigh or speak in a tone of voice that lacks enthusiasm
13. Make comments as they walk away from a conversation that are not loud enough to understand, but loud enough to know they said something
14. When done with their work, do not offer to help others”

“So coaching starts with your own attitude adjustment for yourself: Instead of frustration, focus on ‘*I want the people I lead to be successful, and my job is to be a mirror to help them be so.*’ Here is a simple coaching framework (followed by an example):



1. State your **purpose**, *'I would like to talk with you about some things I have observed that may be getting in the way of your success.'*
2. State the specific **behavior**, *'I notice that during the last several staff meetings, when you come in you sit turned away from others. You don't make eye contact or speak up about the issues when asked for input.'*
3. State the **effect** that behavior has, *'It might not seem like a big thing, but when you don't show an interest through your body language and by participating in the discussion, it has the effect on the team of bringing down the mood, and making others feel like you are not on board with our work.'*
4. State your **expectation**—specifically what you want to see instead: *'What I want to see is you joining in the conversation, sharing your ideas—even if you disagree! And for the body language, I'd like you to pay attention to this*

*by basically sitting up at the table and making more eye contact with the team.'*

5. State the **result** the new behavior will have: *'When I see you participating more, I am more confident that we are working as a team and we'll reach our goals. Others will see this, too, and will have more trust in you as a team member.'*
6. **Ask** if they have questions: *'What do you think?'*  
This opens the door for dialogue."

"Use this same coaching framework—**Purpose, Behavior, Effect, Expectation, Result and Ask** – for when you see them getting it right!"



Contact Jo Anne Preston for individual or group coaching at 608-644-3261 or [jpreston@rwhc.com](mailto:jpreston@rwhc.com). For Info re the RWHC Leadership Series 2011-2012 go to [www.rwhc.com](http://www.rwhc.com) and click on "Services" or contact RWHC Education Coordinator Carrie Ballweg at 608-643-2343 or [cballweg@rwhc.com](mailto:cballweg@rwhc.com).

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