

Aging Population Drives Physician Shortage

The following is from a Wisconsin Hospital Association (WHA) press release on a report by the Wisconsin Council on Medical Education and Workforce (WCMEW), *Who Will Care for Our Patients?* Special thanks to George Quinn at WHA for doing the heavy lifting for this report and to Nancy Nankivil at the Wisconsin Medical Society for leading the physician survey. The report is available at www.wha.org

“The wait to see a doctor could get longer if projections on the supply of and demand for physicians are accurate. Wisconsin hospitals and physician clinics say recruiting physicians is more difficult than ever before, and they expect the situation to worsen according to a new report released today by the Wisconsin Council on Medical Education and Workforce.”

“‘*Who Will Care For Our Patients?*’ is a report written by the Wisconsin Hospital Association on behalf of WCMEW. One of its most alarming findings is that Wisconsin is short nearly 374 primary care physicians across 31 counties. Milwaukee alone currently needs 20 additional primary care physicians to meet inner city demands. Experts say this shortage can create a bottleneck in the health care system.”

“‘Primary care doctors have several key roles in health care: They are the point of contact for people with undiagnosed health concerns, and they help pa-

tients navigate the health care system when they need on-going care or a referral to a specialist,’ said WCMEW Chair Carl Getto, MD, senior vice president of medical affairs and associate dean for hospital affairs at the University of Wisconsin Hospitals and Clinics. ‘When patients are sick and can’t get in to a physician, they enter the health care system through the hospital emergency room.’ ”

“The greatest increase in the demand for physicians centers on three specialties: family practice, internal medicine and the hospitalist—an expert in providing hospital-based care.”

“A Wisconsin Medical Society survey of 19 chief medical officers representing more than 5,000 physicians found that:

- 63% said a shortage of physicians is requiring them to alter how they delivered services;
- 53% said patient wait times have lengthened;
- 26% indicated that they are limiting acceptance of new patients; and,
- Nearly 60% said they have added advanced practice providers, such as nurse practitioners and physician assistants.”

What is driving the shortage?—“The report identifies several key factors that contribute to the physician shortage. One is the nearly stagnant growth in the number of physicians graduated from Wisconsin’s two medical schools—the University of Wisconsin School of Medicine and Public Health (UWSMPH) and the Medical College of Wisconsin (MCW). On average,



336 medical students have graduated each of the past six years (195 for MCW and 141 for UWSMPH), a number that has remained constant for two decades. Only about 38 percent of graduates stay and practice medicine in Wisconsin.”

“The aging of Wisconsin’s population will have a dramatic impact on utilization, according to WHA Senior Vice President George Quinn, who authored the report on behalf of WCMEW. Wisconsin’s population over the age of 75 will increase 68 percent from 2006 to 2030, while the number of people living here that are between the ages of 65 and 74 will grow by 94 percent.”

“‘No single factor will impact our health care delivery system as much as the aging of our population,’ Quinn said. ‘Older people require more health care, and we’re expecting our graying demographics to drive up the number of physician office visits by 65 percent from 2006 through 2030.’”

“Tim Bartholow, MD, Wisconsin Medical Society senior vice president said, ‘This is a concerning and sobering report. The health of our citizens is tied in part to our ability to access health care, plain and simple,’ said. ‘The data in this report makes it clear that if we don’t take action to address the physician workforce shortage now, particularly in rural and inner city areas, the health of our children, our parents and our own health is at risk.’”

How do we avoid a crisis?—“The demand for physicians will grow by nearly 30 percent in the next 10 years, and more than double in two decades. Yet the

supply of physicians is projected to increase by just 13 percent in 10 years and 20 percent by 2030. Worse still, demand for primary care physicians is even more acute.” To avoid a crisis, WCMEW made a series of recommendations:

- **“Enroll students in medical schools who will practice in Wisconsin**—Develop a program within one of the Wisconsin medical schools to recruit and train individuals who are likely to practice in inner-city Milwaukee, modeled after the UW’s successful Wisconsin Academy for Rural Medicine (WARM), which focuses on admitting students likely to practice medicine in rural Wisconsin.”
- **“Develop new care delivery models**—Even if efforts to increase the number of primary care physicians practicing in Wisconsin are successful, there will still be a shortage. Advanced practice providers, which include but are not limited to nurse practitioners and physician assistants, have demonstrated that within their scope of practice they can deliver quality care with high patient satisfaction.”
- **“Attract physicians to Wisconsin, and keep them here**—Competition among states is keen for physicians. Making physicians aware of opportunities in Wisconsin is essential. WCMEW took the first step in enhancing Wisconsin’s ability to recruit physicians with the recent launch of a career opportunity Web site, www.WisconsinPhysicianCareers.org Less than two months old, the site has already posted more than 600 positions for physicians in Wisconsin.”
- **“Target and enhance funding for medical education**—The Wisconsin Medicaid program has significantly reduced funding for medical education, shifting that burden onto commercial payers. The State Health Plan calls for ‘ensuring an adequate supply of primary care professionals.’ The State of Wisconsin could take a step toward meeting that stated goal by ensuring the medical education of primary care professionals is adequately funded. The Wisconsin Medicaid program should fund graduate medical education and target it specifically at the greatest need—primary care.”
- **“Create an infrastructure to guide medical education in Wisconsin**—While WCMEW has served as a platform for addressing the physician

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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as a platform for addressing the physician workforce shortage, the single largest obstacle is finding good data to accurately forecast demand. A data system must be designed that will help define and quantify the need for physicians in Wisconsin.”

Rural Health Policy Institute—This Year, Be There
January 26-28th, 2009 Washington DC
Information at: www.ruralhealthweb.org

The Wisconsin Council on Medical Education and Workforce (WCMEW) has seven member organizations that joined forces to ensure that Wisconsin maintains enough supply of physicians. Members include: the Wisconsin Hospital Association, the Wisconsin Medical Society, the University of Wisconsin School of Medicine and Public Health, the Medical College of Wisconsin, the Rural Wisconsin Health Cooperative, the Wisconsin Academy of Family Physicians, and the Wisconsin Academy of Physician Assistants.

The Wisconsin Office of Rural Health (WORH) has a widely respected physician recruitment program that focuses on rural communities; contact Randy Munson, WORH Physician Recruitment Program Manager at 800-385-0005 or rlmunson@wisc.edu

RWHC & WORH jointly sponsor a career opportunity website, Rural Health Careers Wisconsin at www.rhcw.org that focuses on opportunities for a wide range of clinical and management positions offered by rural healthcare providers in Wisconsin.

RWHC has just developed a “grow your own” model contract for a hospital based Pre-Employee Educational Loan Program as well as suggestions for how such a program should be managed. Both will soon be available at www.rwhc.com

We Don't Get What We Don't Pay For

From “Where have all the primary docs gone?” in the *Iowa City Press-Citizen* by Brian Morelli, 10/2/08:

“Choosing to go into family medicine was simple for University of Iowa medical student Jamie Wallace. She grew up seeing the same doctor from birth through college. That continuity is something she values in health care and something she wants to give

back. ‘For some people, maybe it's about the money, but not for me. You have to love what you are doing.

You have to be proud of what you are doing,’ the 25-year-old fourth-year medical student said. ‘Family medicine is what I want to do.’ ”

“Wallace plans to do a residence in family medicine, a primary care field, after graduation this spring. This is the exception to the norm. The number of medical students entering primary care is declining, according to a recent study published in the *Journal of the American Medical Association*. That study found that only 2 percent of graduating medical students planned to work in primary care internal medicine, which is down from about 9 percent, according to data from a similar study in 1990.”

“ ‘The effect of the decline is being felt most in rural communities, inner cities and among the elderly in areas where health insurance requires visits to primary care doctors,’ said Paul James, professor and head of the UI Department of Family Medicine. Primary care, which includes the fields of family care, internal medicine, pediatrics and obstetrics and gynecology, essentially refers to first-stop doctors. Many patients must see these doctors before receiving specialized procedure-based care.”

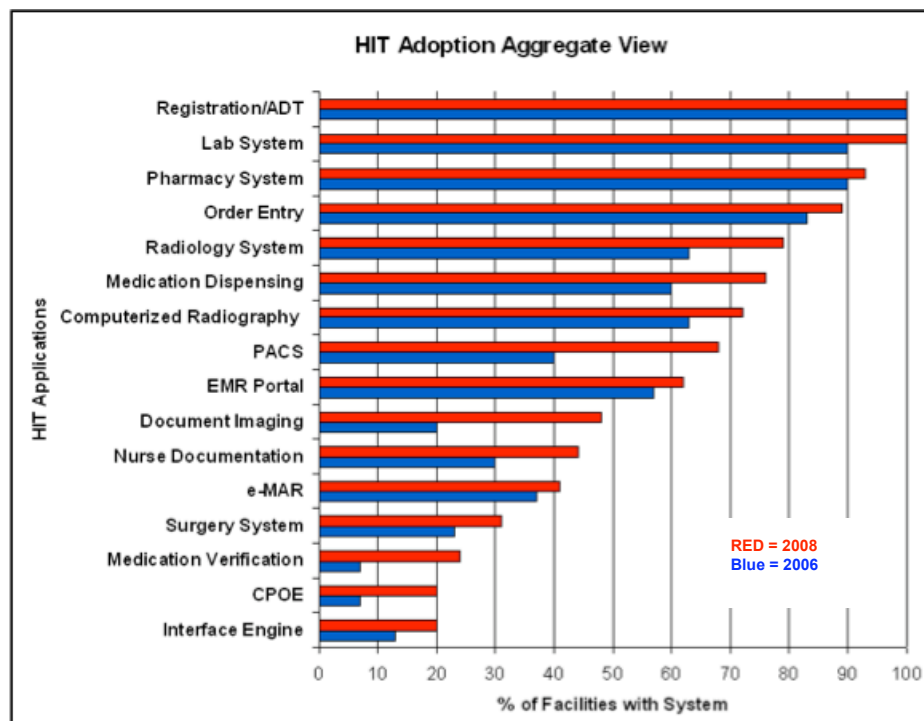
“Since 2004, the number of students entering primary care internal medicine, which is included in the primary care figures, has fallen from 19 percent to 10 percent among spring 2008 graduates. The downward trend has been going on for most of the decade, James said. He said a change is needed in the health care reimbursement system to combat the issue.”

“He sees inequities when agencies such as Medicaid and Medicare pay more for specialized procedural care than for primary care, which James said is more effective. ‘The current system encourages doctors to push more procedures, medicine and imaging on patients than may be necessary,’ James said. The system allows doctors in procedure-based specialty fields to see bigger paydays, better hours and less chance of emergency calls in the middle of the night, he said, which is attractive for students. ‘They are going for higher payment and higher lifestyle specialties,’ James said of graduating students.”

Rural Health Information Technology Scan

The Wisconsin Office of Rural Health and the Rural Wisconsin Health Cooperative have just released an update of *Density of HIT Adoption in Wisconsin Rural Hospitals*. This study describes levels of health information technology (HIT) system adoption in rural Wisconsin hospitals; it is available at www.rwhc.com. The study is intended to help rural facilities benchmark their HIT programs against those of their peer facilities as well as to inform HIT policies sensitive to rural communities. The primary findings are:

- HIT adoption in rural Wisconsin hospitals is increasing at a steady pace, with adoption rates of identified systems going from 50% in 2006 to 60% in 2008. Also, many study participants noted plans for 2008-2009 implementations.
- Even with these gains, only 18% of these rural hospitals had high rates of adoption (high is defined as 13-16 identified systems) compared to 40% of all Wisconsin hospitals (per 2008 WHA data on all Wisconsin hospitals).
- Large organization assistance does not predict HIT adoption, with 12 of the top 13 adopters receiving no outside assistance from larger organizations.



- Rural Wisconsin hospitals tend to opt for more integration in their HIT strategy, with 77% using an integrated strategy, 20% using a cluster strategy, and 3% using a best of breed strategy.
- Rural Wisconsin hospitals generally lay a foundation of basic clinical systems before building to advanced patient safety systems (i.e. hospitals, in general, implement advanced systems after significant preliminary HIT applications are in place).
- The smallest third of rural respondents had 23% fewer systems implemented than the overall rural pool. This is likely because small hospitals have less capital and fewer staff, and HIT systems don't always scale down well, since the return on investment is generally dependent on volume. This disparity would have been 10% higher if not for projects funded by various federal agencies.

Public Policy Recommendations

- Continue to fund rural hospital HIT. While it is promising to see HIT adoption increases from 2006 to 2008, the data also highlights the significant ongoing cost burden associated with the adoption of HIT systems, especially advanced clinical systems.
- When designing new programs or revising existing ones, policy makers should understand the realities of rural-HIT implementation as noted above. New programs should be designed with sensitivity to proven rural HIT success factors and with reasonable implementation timeframes.
- More data is needed that helps small rural facilities understand rurally relevant HIT implementation strategies and policy makers understand the unique qualities of rural HIT—data that both helps rural facilities make good HIT decisions and provides all stakeholders with a broader picture of the national rural HIT landscape.

“From the Middle”: Social Entrepreneurship

The following is from a brief in the Harvard Business School Working Knowledge Series, *Putting Entrepreneurship in the Social Sector*. It highlights a new casebook by 4 Harvard Business School professors that argues that the social sector should take an entrepreneurial approach. Sean Silverthorne interviews one of the co-authors, Jane Wei-Skillern. The complete brief is available at www.exed.hbs.edu

Sean Silverthorne: “Why did you and your coauthors write this book? Who is your target audience?”

Jane Wei-Skillern: “We wanted to take the ideas from our MBA social entrepreneurship course, which has been taught at HBS for many years, beyond the walls of the HBS classroom. The book is geared toward students with whom we would not otherwise have the opportunity to engage directly, instructors who are currently teaching or have an interest in developing social entrepreneurship courses, and last but not least, practitioners themselves, who are seeking to achieve mission impact as effectively, efficiently, and sustainably as possible.”

Q: “What do you mean by social entrepreneurship?”

A: “We define social entrepreneurship as innovative, social value-creating activity that can occur within or across the nonprofit, government, or business sectors. While virtually all enterprises, commercial and social, generate social value, fundamental to this definition is that the drive for social entrepreneurship is primarily to create social value, rather than personal or shareholder wealth.”

“Our definition of social entrepreneurship extends beyond more narrow definitions of social entrepreneurship that simply apply business expertise and market-based skills to nonprofits. We believe that the opportunities and challenges in the field of social entrepreneurship require not only the creative combination and adaptation of social and commercial ap-

proaches, but also the development of new conceptual frameworks and strategies tailored specifically to social value creation.”

“A perfect example of this is network approaches, which we cover in one of the chapters in the book. A network approach requires leaders to focus not only on management challenges and opportunities at an organizational level, but also more broadly on how to mobilize resources both within and outside organizational and sectoral boundaries to create social value. Social entrepreneurs who have innovated using network approaches are in many ways ahead of the curve, even relative to leaders in other fields.”

Q: “Despite the growing magnitude of the social sector, many of the challenges these organizations hope to address continue to persist. What difference can social entrepreneurship make?”

A: “Without question, the social sector has contributed in significant ways to addressing major societal problems, yet traditional approaches are still falling short, especially as the intensity and complexity of social problems has grown.”

“Solving these problems is not just a matter of mobilizing more resources to the field, but also developing entirely new models and ways of achieving sustainable mission impact. This reality makes social entrepreneurship approaches that achieve better leverage on resources, enhance effectiveness through creative partnerships, and enable more sustainable social impact increasingly relevant.”

“Social entrepreneurs stay relentlessly focused on their missions and seek to continually innovate to achieve greater impact with the resources that they are able to mobilize.”

Q: “On the theme of alliances and networks, the book offers a case on the Guide Dogs for the Blind Association (GDBA), which you coauthored. What does this case tell social entrepreneurs about the power of cross-organization alliances and the difficulties in putting them together?”

A: "This case is a prime example of social entrepreneurship because it illustrates how a social entrepreneur [GDBA chief executive Geraldine Peacock] used an innovative network approach to achieve tremendous mission impact by mobilizing resources and building capacity beyond GDBA's immediate control."

RWHC Eye On Health



I Want to Be a Nurse When I Grow Up

Editor's note: Those of us who work in rural health have many stories to tell. I was privileged to read this unpublished one and receive permission from the writer to share it:

" 'I want to be a nurse when I grow up.' This is such a simple statement but there was a long road to get there. Well, I am a nurse but I am not sure I will ever grow up. I believe that process of growing up isn't done until death. Each turn in life has so much more to show us.

I was caring for a gentle man last night that was close to death and he was having trouble swallowing his medication so I said, 'Let's try some applesauce with them.' He took the first bite and he looked at me and said, 'That is what I will miss the most; The Apples.' Something as simple as that statement shows us how precious the little things in life are yet so many people never see them."

"The organization worked with other nonprofits, government agencies, and private sector groups as equals, to build a network of long-term, trust-based relationships to deliver on the mission."

"A key lesson from this case is that successful networks depend upon a willingness among all participants to invest significant resources (not just financial), relinquish control, and share recognition with their partners to advance the mission, not their organizations."

Q: "What are you working on next?"

A: "In researching several of the cases on networks for my course and the casebook, I was struck by the tremendous potential for this approach to transform the effectiveness of the sector. Thus, my current research focuses on these networked nonprofits and on deepening our understanding of how to build such networks."

"I am developing a series of additional cases on how investing in a range of strategic networks can be a powerful lever for nonprofits to achieve greater social impact. This research explores specifically how these trust-based networks that leverage local resources in innovative ways can be catalyzed and maintained. Through an examination of a range of network strategies, from funder networks to intra-organizational networks to grassroots networks, this research is aimed at identifying approaches for increasing mission impact through network building."

"As a teenager, I had many problems trying to figure out what I wanted to do. I loved to sing and dance and of course wanted to be a movie star and Olympic figure skater but in the small town I lived in, they were very big dreams for a B+ student with not a lot of talent. My older sister was a straight A student and she wanted to be a nurse and I thought I would be very good at that as well. Well my sister did go to nursing school. My parents arranged for her to go to St Mary's in southern Minnesota. She came home after 2 semesters with failing grades. My parents were heart-broken. She was 4 years older than I was and when it was my turn in 4 years to start looking for a college, I ran into a big obstacle. My father died the first week of my senior year of a heart attack."

"I spent what should have been a wonderful final year reeling from disbelief and depression. He had not been sick a day in his life. We were very close and he was always a go between for my mother and me as we had frequent disagreements. With that buffer gone, our relationship became explosive and angry. She decided my place to go to school. I would go to Dental Assistant school because there was no way she was going to waste her money sending me to nursing school when my older sister who got straight A's couldn't make it

through school and the best I could come up with was a B+ average.”

“Well I did get my Dental Assistant certification and actually used it for about 6 months. By this time, I had gotten married, and had a baby and my husband and I moved. Since my story of nursing is a long one, I will make it short here. I gave up the idea of being a nurse after I had four children in 6 years and my husband and I struggled to keep our heads above water to support them. I became a waitress, a chef, a prep cook, I was a receptionist for a vet, and worked with an accountant. I had many jobs and I did all of them well. I also ran into an illness that finally took me out of the work force for many years. Depression and anxiety disorders were the problem. I was suicidal for several years.”

“I attempted suicide at least 3 times and was hospitalized 3 times. I had shock treatment and finally I was labeled as mentally disabled. This label has been the one thing that kept me for years from even attempting to finish my dreams of being a nurse. As a person with a disability, if you work or appear to be capable of being able to care for yourself, you no longer get disability or any help. Because we had the children to support and my depression was unpredictable, I was afraid to even attempt working. In addition, if you apply for a job and state you are disabled even though you are still supposed to be considered equally, most places will pass you by. For this reason it is amazing that I am working where I am today.”

“About 5 years ago, my daughters were old enough to be starting college and since they were kind of shy and had no clue how to go about getting into school I encouraged them to just take a few classes. I even said I would take one with them. Well, I took one and I was hooked. I started working towards getting my general education credits done. I also applied to the nursing program just to see if I could get in. Then because my husband and I had become foster parents, I had to drop the idea of nursing school. But, the next fall I decided since we had been working with a lot of developmentally delayed children, I’d try to get a degree in developmental disabilities. I took several courses in that field and started realizing that there was not a lot of

work for anyone in that field in this area so I again looked at nursing school. Well, the requirements had become stricter to get into school and the waiting list was longer. I decided I was going to do it this time no matter what.”

“I was very surprised when they called me that summer to let me know I had been picked in the lottery to start in the fall. I still wasn’t done with my general education credits but I said that this time it was do it or give it up. All this time I continued to struggle with depression and anxiety. To go to classes with others that had no idea I was

considered disabled and to not tell any of my teachers or ask for any special consideration was a very difficult road. I felt if I had to do that, then I shouldn’t even be considering becoming a nurse because it is such an important job. Some teachers didn’t see things my way. There were classes in which I struggled.”

“Before I started the nursing program, I had been getting straight A’s for the first time in my life—a 4.0 grade point average. In nursing school, I had to maintain above a 78% as everyone knows in all classes. I was lucky there was another student in my nursing class that was about my age and we stuck together and studied hard. In a class of 10 that started, we were the only two that made it through without having to retake any of the classes. We came close to not making it but we came through in the 2 years, including having to take several of our general education classes at the same time. I didn’t get that A average I wanted but I always said ‘what is so bad about a B+’. It is passing.”

“I graduated and was immediately hired in a hospital. All this time I continued to get SSI disability and during school, my husband and I continued to take in foster children. We now have had over 30 foster children in our home and currently have four, although we will have two of them go home soon. After working for 6 months, Social Security contacted me and stated I would lose my disability because I had been working continually for 6 months and had made over the wage limit they set. I welcomed the letter that removed the label mentally disabled from me.”

17th Annual Monato Essay Prize Now \$2,000

A \$2,000 Prize for the Best Rural Health Paper by a University of Wisconsin student. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at

www.rwhc.com/Awards/MonatoPrize.aspx

“I still struggle daily with both depression and anxiety. However, I know the signs and symptoms of trouble better than most and I can see a lot of things in other people that they don’t know I see. I see signs of depression being ignored and as well as the fear of being diagnosed with a mental disorder because of the stigma that goes with it.”

“The world is getting better but so many of the nurses I work with would be aghast at the story I have just told. I see them saying ‘I am working beside a nurse that has been locked up in a psyche ward and had shock treatment.’ ‘How could that possible happen?’ ‘Don’t they have to check these people out?’ ‘What if she goes nuts?’ ‘Isn’t she taking a lot of drugs that impair her ability to take care of patients?’ It is sad that I cannot explain to them or make them understand that people with mental disabilities are a lot of times very capable people with an illness and as long as they treat that illness and care for themselves, they are good if not better nurses than most. I do understand the man that tells me. ‘I think I will miss the apples the most.’ I



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know he is telling me to enjoy the simple pleasures in life and give people kindness and understanding.”

“Nursing has been difficult at times. I have taken in more foster kids and the stress level at times has been too much. I have found that some days I hate the idea of going to work and that I have no more of myself to give. I know that I have learned more than I ever dreamed I would since getting out of school. At work, I continue to try and expand my nursing career and may even continue my education. I think I may want to teach in the future. I want to teach other nurses especially the young ones that nursing is a demanding job both physically and emotionally and you need to take care of your health both physically and mentally. I have cut down my hours to part time for now and I will continue to assess my health and make sure my patients are safe with me caring for them. The one thing I have always been able to do is to know when I need to take care of me. That is my big tidbit of knowledge for everyone.”

“Enjoy the Apples!!”

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