

Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2009

## What's Next?

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

This is the best of times and the worst of times. I've always wanted to start with this line taken from the beginning of Charles Dickens's "A Tale of Two Cities." It certainly fits well today. Some may quibble with the "best of times" but as an aging optimist, each new day above ground is always welcomed.

President Obama has now signed into law the largest economic stimulus bill we have ever seen in the U.S. There are without a doubt some good things and some not so good things in it. Strong feelings for and against the wisdom of many of the provisions exist.

Don't get me started about the tradeoffs that were made or not made to help rural health. In any event, I'm moving on and leaving to people with more time and more inside knowledge to understand what happened. (Being asked to write an editorial is really great for a person's mental health.)

This was a huge bill with many complex issues that arguably needed to move very quickly to help slow a tanking economy. In this situation, I agree with the old adage, "it is better to be approximately right than to be exactly wrong."

There was widespread agreement about the need for the government to have stepped in. You don't have to be a "Keynesian economist" to see that. When many to most of us get worried about our economic security, we spend less. It is just common sense that the Federal government needed to act to fill the gap temporarily by spending more. Action was needed to limit the recession's impact on our fears and loss of jobs.

We clearly need to be prepared for a rocky road over the next year or more. We will individually and collectively face many important tough questions. However, the toughest question will be what do we want next for our country? I, for one, believe that we will be better off if our collective answer is not getting back to the last two decade's "business as usual."

We need to seek a "new normal." We need a country that works to avoid the traps of excessive consumerism and borrowing while making sure basic needs are met. This excess hit us both as individuals when we bought housing well beyond our needs and means, and when our Federal government added recklessly to our national debt.

Our banking system lost its way. There are many individuals, of both major political parties, who have more than a fair share of responsibility for our current mess. And we the people also played a starring role. As individuals, we need to borrow for appropriate education, transportation and housing. Our organizations need to borrow to grow jobs. But we have become a culture too



comfortable with borrowing from tomorrow's basics for today's luxuries.

It is my hope that we as a people find a better balance, individually and collectively, between consumption and investment.

My father came of age in the "Great Depression." In many ways he was not a role model, but like many of his generation, that experience led to life with a healthy measure of thrift and making good use of what he had. When my wife and I cleaned out his house after he passed, our favorite discovery was a box carefully labeled and full of "String Too Short To Use."

I am not suggesting that we should turn into a redo of those from an earlier era. However, I do believe we have an opportunity, in our homes, at work and in our communities to have a discussion about who we want to be, to make better use of the "short strings" that come our way.

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## Want Good Health? Family & Friends Matter

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From *Outliers* by Malcolm Gladwell as part of an online review at <[www.nytimes.com](http://www.nytimes.com)>:

"Roseto Valfortore lies one hundred miles southeast of Rome, in the Apennine foothills of the Italian province of Foggia... In January of 1882, a group of eleven Rosetans—ten men and one boy—set sail for New York. They spent their first night in America sleeping on the floor of a tavern on Mulberry Street, in Manhattan's Little Italy. Then they ventured west, ending up finding jobs in a slate quarry ninety miles west of the city in Bangor, Pennsylvania. The following year, fifteen Rosetans left Italy for America, and several members of that group ended up in Bangor as well, joining their compatriots in the slate quarry."

"Those immigrants, in turn, sent word back to Roseto about the promise of the New World, and soon one group of Rosetans after another packed up their bags and headed for Pennsylvania, until the initial stream of immigrants became a flood. In 1894 alone, some

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twelve hundred Rosetans applied for passports to America, leaving entire streets of their old village abandoned."

"They built a church and called it Our Lady of Mount Carmel, and named the main street on which it stood Garibaldi Avenue, after the great hero of Italian unification. In the beginning, they called their town New Italy. But they soon changed it to something that seemed more appropriate, given that in the previous decade almost all of them had come from the same village in Italy. They called it Roseto."

"In 1896, a dynamic young priest—Father Pasquale de Nisco—took over at Our Lady of Mount Carmel. De Nisco set up spiritual societies and organized festivals. He encouraged the townsfolk to clear the land, and plant onions, beans, potatoes, melons and fruit trees in the long backyards behind their houses. He gave out seeds and bulbs. The town came to life. The Rosetans began raising pigs in their backyard, and growing grapes for homemade wine. Schools, a park, a convent and a cemetery were built. Small shops and bakeries and restaurants and bars opened along Garibaldi Avenue. More than a dozen factories sprang up, making blouses for the garment trade... Roseto Pennsylvania was its own tiny, self-sufficient world—all but unknown by the society around it—and may well have remained so but for a man named Stewart Wolf."

"Wolf was a physician. He studied digestion and the stomach, and taught in the medical school at the University of Oklahoma. He spent summers at a farm he'd

**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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bought in Pennsylvania... ‘One of the times when we were up there for the summer—this would have been in the late 1950’s, I was invited to give a talk at the local medical society,’ Wolf said, years later, in an interview. ‘After the talk was over, one of the local doctors invited me to have a beer. And while we were having a drink he said, ‘You know, I’ve been practicing for seventeen years. I get patients from all over, and I rarely find anyone from Roseto under the age of sixty-five with heart disease.’ ”

“Wolf was skeptical. This was the 1950’s, years before the advent of cholesterol lowering drugs, and aggressive prevention of heart disease. Heart attacks were an epidemic in the United States. They were the leading cause of death in men under the age of sixty-five. It was impossible to be a doctor, common sense said, and not see heart disease. But Wolf was also a man of deep curiosity. If somebody said that there were no heart attacks in Roseto, he wanted to find out whether that was true.”

“Wolf approached the mayor of Roseto and told him that his town represented a medical mystery. He enlisted the support of some of his students and colleagues from Oklahoma. They pored over the death certificates from residents of the town, going back as many years as they could. They analyzed physicians’ records. They took medical histories, and constructed family genealogies. ‘We got busy,’ Wolf said. ‘We decided to do a preliminary study.’ ”

“The results were astonishing. In Roseto, virtually no one under 55 died of a heart attack, or showed any signs of heart disease. For men over 65, the death rate from heart disease in Roseto was roughly half that of the United States as a whole. The death rate from all causes in Roseto, in fact, was something like thirty or thirty-five percent lower than it should have been.”

“Wolf brought in a friend of his, a sociologist from Oklahoma named John Bruhn, to help him. ‘I hired medical students and sociology grad students as interviewers, and in Roseto we went house to house and talked to every person aged twenty one and over,’ Bruhn remembers. This had happened more than fifty years ago but Bruhn still had a sense of amazement in his voice as he remembered what they found. ‘There was no suicide, no alcoholism, no drug addiction, and very little crime. They didn’t have

anyone on welfare. Then we looked at peptic ulcers. They didn’t have any of those either. These people were dying of old age. That’s it.’ ”

“Wolf’s profession had a name for a place like Roseto—a place that lay outside everyday experience, where the normal rules did not apply. Roseto was an outlier.”

“Wolf’s first thought was that the Rosetans must have held on to some dietary practices from the old world that left them healthier than other Americans. But he quickly realized that wasn’t true. The Rosetans were cooking with lard, instead of the much healthier olive oil they used back in Italy. Pizza in Italy was a thin crust with salt, oil, and perhaps some tomatoes, anchovies or onions. Pizza in Pennsylvania was bread dough plus sausage, pepperoni, salami, ham and sometimes eggs. Sweets like biscotti and taralli used to be reserved for Christmas and Easter; now they were eaten all year round. When Wolf had dieticians analyze the typical Rosetan’s eating habits, he found that a whopping 41 percent of their calories came from fat. Nor was this a town where people got up at dawn to do yoga and run a brisk six miles. The Pennsylvanian Rosetans smoked heavily, and many were struggling with obesity.”

“If it wasn’t diet and exercise, then, what about genetics? The Rosetans were a close knit group, from the same region of Italy, and Wolf next thought was whether they were of a particularly hardy stock that protected them from disease. So he tracked down relatives of the Rosetans who were living in other parts of the United States, to see if they shared the same remarkable good health as their cousins in Pennsylvania. They didn’t.”

“He then looked at the region where the Rosetans lived. Was it possible that there was something about living in the foothills of Eastern Pennsylvania that was good for your health? The two closest towns to Roseto were Bangor, which was just down the hill, and Nazareth, a few miles away. These were both about the same size as Roseto, and populated with the same kind of hard-working European immigrants. Wolf combed through both towns’ medical records. For men over 65, the death rates from heart disease in Nazareth and Bangor were something like three times that of Roseto. Another dead end.”

“What Wolf slowly realized was that the secret of Roseto wasn’t diet or exercise or genes or the region where Roseto was situated. *It had to be the Roseto itself.* As Bruhn and Wolf walked around the town, they began to realize why. They looked at how the Rosetans visited each other, stopping to chat with each other in Italian on the street, or cooking for each other in their backyards. They learned about the extended family clans that underlay the town’s social structure. They saw how many homes had three generations living under one roof, and how much respect grandparents commanded. They went to Mass at Our Lady of Mt. Carmel Church and saw the unifying and calming effect of the church. They counted twenty-two separate civic organizations in a town of just under 2000 people. They picked up on the particular egalitarian ethos of the town, that discouraged the wealthy from flaunting their success and helped the unsuccessful obscure their failures.”

“In transplanting the *paesani* culture of southern Italy to the hills of eastern Pennsylvania the Rosetans had created a powerful, protective social structure capable of insulating them from the pressures of the modern world. The Rosetans were healthy because of where they *were* from, because of the world they had created for themselves in their tiny little town in the hills.”

“I remember going to Roseto for the first time, and you’d see three generational family meals, all the bakeries, the people walking up and down the street, sitting on their porches talking to each other, the blouse mills where the women worked during the day, while the men worked in the slate quarries, Bruhn said. ‘It was magical.’ ”

“When Bruhn and Wolf first presented their findings to the medical community, you can imagine the kind of skepticism they faced. They went to conferences, where their peers were presenting long rows of data, arrayed in complex charts, and referring to this kind of gene or that kind of physiological process, and they talked instead about the mysterious and magical

## RWHC Eye On Health



“I love my new Doc. He says the best thing for my health is taking it easy with friends in a familiar place.”

benefits of people stopping to talk to each other on the street and having three generations living under one roof. Living a long life, the conventional wisdom said at the time, depended to a great extent on who we were—that is, our genes. It depended on the decisions people made—on what they chose to eat, and how much they chose to exercise, and how effectively they were treated by the medical system. No one was used to thinking about health in terms *of a place.*”

“Wolf and Bruhn had to convince the medical establishment to think about health and heart attacks in an entirely new way: they had to get them to realize that you couldn’t understand why someone was healthy if all you did was think about their individual choices or actions in isolation. You had to look beyond the individual. You had to understand what culture they were a part of, and who their friends and families were, and what town in Italy their family came from. You had to appreciate the idea that community—the values of the world we inhabit and the people we surround ourselves with—has a profound effect on who we are. The value of an outlier was that it forced you to look a little harder and dig little deeper than you normally would to make sense of the world.”

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## Restoring Balance to American Medicine

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From a commentary, “Recruiting the docs we need: Make primary care competitive with specialties in terms of pay,” by Richard Scheffler in *Modern Health Care*, 1/26/09:

“In a national survey of medical students released in September 2008, only 2% said that they were considering general internal medicine as a career. This is a troubling statistic, given that medical research increasingly points to robust primary-care services as a linchpin of high-quality healthcare.”

“Healthcare quality experts have documented that people living in regions with more primary-care doctors enjoy better overall health, even after accounting for age and income differences. These regions also have far lower healthcare costs. That makes primary care better for our health and our pocketbooks. The Dartmouth Atlas also has shown repeatedly that regions with high healthcare expenditures display little if any improvement in patient satisfaction or health outcomes over less costly areas. More treatment does not equal better health.”

“So how do we bring the doctors of tomorrow back into the primary-care fold? I think we should frame the doctor-supply question as part of a broader, workforce conversation.”

“Doctors will return to primary care when the system rewards them for doing so. That involves reforms to the way we pay for medical services and the types of services we will pay for. Let’s make primary-care pay better. Let’s pay for a more diverse healthcare workforce, taking the burden off physicians and making for a more productive system.”

“Inducements for new doctors, such as debt relief, will help. On the payment side, there are promising innovations in what are called bundling configurations—the use of a single payment for a group of related services.”

“Payments can cover preventive care and health education, which will encourage greater use of health professionals such as physician assistants and nurse practitioners. In turn, that will make medicine the team effort it needs to become to succeed in today’s complex healthcare world. It also will make life better for primary-care physicians.”

“Other promising reforms include meaningful and well-designed pay-for-performance measures to reward top-performing medical teams, and greater information technology implementation to improve the productivity of the doctors we already have. I do think we need a modest, 10% to 20% increase in the number of medical students over the next 10 years. But we should think hard before we invest massive sums to produce doctors who will enter a healthcare system that punishes them for choosing primary care.”

“We should first make sure that we are sending them into a healthcare system that makes sense—and makes wise use of our money.”

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## UW Med School Seeks Rural Applicants

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The Wisconsin Academy for Rural Medicine (WARM)



University of Wisconsin  
**SCHOOL OF MEDICINE  
AND PUBLIC HEALTH**

is a rural medical education program at the University of Wisconsin School of Medicine and Public Health (UW SMPH). The goal of the program is to attract applicants to the UW SMPH who are committed to practicing rural medicine and eventually increase the number of physicians practicing in rural Wisconsin.”

**What’s the Curriculum?**—“WARM is a student-centered program that will prepare students for residency in any specialty area. Students will spend the first two years in Madison completing the required basic science courses and can also participate in a rural health elective and the Rural Health Interest Group.”

“During years three and four of medical school, WARM students will be assigned to a ‘regional and rural learning community’ and will complete the required clerkships in those two locations. WARM is partnering with Marshfield Clinic, Gundersen Lutheran and Aurora BayCare and their respective rural clinics and hospitals to host students. Throughout years three and four, WARM students will also follow a longitudinal rural curriculum and complete a community project. By completing clerkships at the regional and rural sites, WARM students will learn how to address medical issues with a rural focus and will learn in a small group format with lots of hands-on opportunities.”

**How do I apply to WARM?**—“WARM is looking for applicants who have a strong desire to practice rural medicine in Wisconsin, who can demonstrate their ties to rural Wisconsin, and have strong records of community involvement. For WARM application instructions, please visit the WARM website at <[www.med.wisc.edu/education/md/warm](http://www.med.wisc.edu/education/md/warm)>.”

**For more information?**—Contact Byron Crouse, MD, Associate Dean for Rural and Community Health, UW SMPH, at [bjcrouse@wisc.edu](mailto:bjcrouse@wisc.edu) or 608.265.6727 or Alison Klein, MPA, Assistant Director, Wisconsin Academy for Rural Medicine, at [alklein2@wisc.edu](mailto:alklein2@wisc.edu) or 608.263.7082.

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## We Fiddle While Kid's Cavities Fester

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From “Train hygienists to provide a wider array of services” in the *Rochester Post Bulletin* by Minnesota State Senator Ann Lynch, 2/16/09:

“In order to help address the growing crisis of dental care access, last year I helped pass a bill that will create a new oral health practitioner, much like a nurse practitioner. This proposal was recommended by the Legislative Commission on Health Care Access as a way to reduce health care costs and improve health outcomes. This is a reform that will save us money and in this time of such economic distress, ideas like this should be embraced.”

“In May 2008, the Minnesota Department of Human Services issued a ‘Report to the Legislature—Critical Access Dental Program—Results and Recommendations.’ Among the recommendations to the Legislature was that consideration should be given to ‘alternative dental workforce models which are effective in increasing access to dental care.’ ”

“The report goes on to say that, ‘Workforce models which are in existence in Alaska and numerous foreign countries have been shown to be effective in reducing oral health disparities and access to care problems. These models could serve as an effective means to increase access to dental care in Minnesota.’ ”

“I am proud of the University of Minnesota and the in-roads it has made to train dentists who practice in underserved

areas, but clearly we need a more expansive solution. Loan forgiveness programs are already in place, but they fall well short of making any substantial impact on student debt.”

“There has been extensive research done on the effectiveness of the program, and it has been implemented in several countries and the state of Alaska. I am confident that Minnesota State Colleges and Universities and the University of Minnesota will provide well-trained, competent individuals, as they have proven and provided to us in so many, many disciplines.”

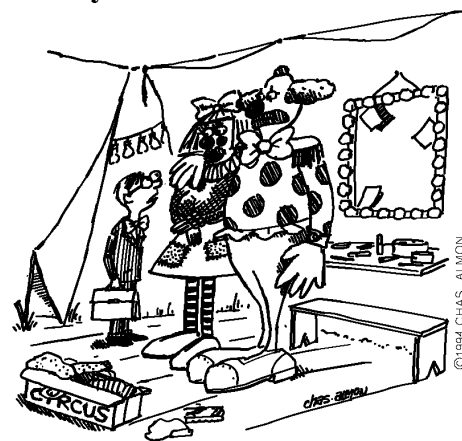
“Thousands of people across Minnesota, especially vulnerable populations such as children, the elderly, low-income and special-needs populations, cannot access the dental care they so desperately need. Patients in rural areas often wait many months to see a dentist, even for serious conditions.”

“Hospital emergency rooms are seeing thousands of repeat patients with unresolved dental problems. There are well over 20,000 visits to Minnesota emergency rooms for the purpose of addressing dental health problems. The cost to Minnesota taxpayers and Minnesota Hospitals is unacceptable. This problem will only get worse over the next 15-20 years, when 60 percent of practicing dentists in Minnesota are projected to retire.”

“The bill I introduced last year was passed unanimously by the Minnesota Senate and was signed into law by Gov. Pawlenty. As a result, the Minnesota

Department of Health convened a work group that has made recommendations on the scope of practice, licensure and regulatory requirements, education programs and curricula, dentist supervision requirements and other issues related to development of a new oral health practitioner. Before March 1, I will introduce a bill that follows the recommendations of the work group as we work toward making the mid-level practitioner a reality.”

### RWHC Eye On Health



“Maybe time for the Dental Examining Board to tear down the high wall keeping out qualified practitioners when a third of we kids have untreated cavities.”

“The mid-level practitioner will be an additional tool for the oral health team. Utilization of a mid-level practitioner is a voluntary option for dentists. Licensed Minnesota dentists may choose to bring this practitioner on to their team. All oral health practitioners must operate under a collaborative agreement that delineates their duties and all expectations of their service, including a plan for consultation, supervision and emergency care.”

“It really is about solving a growing problem and ensuring that no one in Minnesota has to use an emergency room to take care of their tooth ache. We need to take action now. We can’t afford to wait.”

#### **17<sup>th</sup> 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](http://www.rwhc.com/Awards/MonatoPrize.aspx)

“A CRNA, in Wisconsin and many other states, is qualified to provide anesthesia services as an independent practitioner, without supervision by an anesthesiologists—CRNAs work as independent medical

professionals. This requires an advanced level of expertise, which makes this hospital ideal for training.”

“The nurse anesthetists at SPMHC are responsible for all the hospital’s anesthesia services. They provide care for patients before, during, and after procedures.”

“ ‘My time with Sauk Prairie’s CRNA team was truly phenomenal. I learned new skills and observed a professionalism rarely seen,’ says Renee Roloff, BSN, RN, SRNA, (student registered nurse anesthetist). ‘I was taught the profound responsibility involved in working as an independent practitioner.’ ”

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### **CRNAs Trained to Serve Rural Wisconsin**

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From a press release, “Nurse anesthetists when you’re under, they’re on top of it,” Sauk Prairie Memorial Hospital & Clinics, 1/23/09:

“In 2008, Franciscan Skemp Healthcare School of Nurse Anesthesia, located in La Crosse, chose Sauk Prairie Memorial Hospital & Clinics as its sole training facility in south central Wisconsin for certified registered nurse anesthetists (CRNAs). Sauk Prairie was selected for its advanced technology, exceptional staff, and welcoming environment.”

“Many people worry about the safety of anesthesia. But today, anesthesia is very safe. This is due, in great part, to the high degree of skill and rigorous training required of the CRNA, an advance-practice nurse with graduate level education and clinical training.”

“ ‘Sauk Prairie offers students substantial exposure to pain management that they do not receive elsewhere. They gain experience as independent practitioners in a highly professional and skilled environment—this is critical for patients,’ says Barb Jochman, program director of the School of Nurse Anesthesia, the only CRNA school in Wisconsin.”

“I was also pleased to spend time in the obstetrics department, learning how to place and manage epidural catheters. The hospital’s CRNAs are very experienced. This gave me the rare opportunity to learn regional anesthesia (blocking pain in a large part of the body without altering consciousness). Their proficiency is impressive.”

“Franciscan Skemp School of Nurse Anesthesia is a joint program between University of Wisconsin-La Crosse and Franciscan Skemp Healthcare, a health care network serving an 11-county area in Wisconsin, Minnesota, and Iowa.”

“Nurses have significant experience in critical care settings prior to acceptance into the anesthesia program at Franciscan Skemp. They’re awarded a master’s degree in biology after completing a demanding curriculum. The new training program at SPMHC increases the number of qualified, self-directed anesthesia professionals in communities across the state. People living in rural areas will have greater access to quality health care without travelling to a larger city.”

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## Future Medical Pros Get Preview

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RURAL HEALTH CAREERS  
WISCONSIN

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 Stoughton Hospital:

"The health care team in surgical scrubs practices suturing wounds, casting broken bones, even performing gall bladder surgery—and they're only in their teens. Every semester a dozen seventh and eighth graders from Stoughton River Bluff Middle School get a hands-on introduction to health care careers through the Scrub Club, a program sponsored by the staff of Stoughton Hospital."

"The idea came out of the Rural Wisconsin Health Cooperative, but Stoughton Hospital has made the Scrub Club its own, beginning with a survey asking students what activities would most interest them."

"The students meet monthly in different departments. The program is chaired by three nurses (Director of Ambulatory Services Teresa DeNucci and Clinical Education Coordinators Mary Quisenberry and Mary Smith), but

Smith notes that 'the staff of every department handled the teaching, and they came up with some creative ways to introduce the students to all the different health care skills.' "

"Scrub Club members learn how to administer an injection into the muscle, start an IV and use laparoscopic surgical equipment—to remove a 'gall bladder' from a watermelon standing in for a human patient. They also practice physical therapy activities like transferring a patient via wheelchair."

"The young participants are issued their own scrub shirts and name tags and sign the same confidentiality agreements that employees must complete. 'The kids have been really enthusiastic, and they never miss a class,' Smith says. 'One student was so excited he showed up a week early.' "

Space Intentionally Left Blank For Mailing