



Review & Commentary on Health Policy Issues for a Rural Perspective – July 1st, 2007

Why Rural Nurses Matter

Pam Myhre, RN, BSN, from Bagley, Wisconsin has won the 2007 Monoto \$1,000 Prize for her essay, "Thank you, nurse." Until recently, Pam worked for 26 years as a nurse at Grant Regional Health Care. She is now enrolled in the Adult Nurse Practitioner Program at the University of Wisconsin.

"What would be the one piece of advice you'd give to a newly graduated nurse?"

It's a question I've been asked so many times over the past 27 years. Students in their last semester in the nursing programs are required to interview a practicing nurse. They're asked to formulate the questions that will help guide their career paths. And inevitably this question comes up.

And for many years my answer is the same. "Start your career in a small, rural hospital." Of course, each time the student is surprised. So often they think that they will learn the most—have the best support—get the most experience—in a large hospital. So, I go on to explain. In the small hospital, you quickly begin to know a little about everything. Instead of learning a lot about one unit, one specialty, the rural hospital nurse becomes a generalist and develops a broad spectrum of knowledge and experience. Then, the students inevitably ask me to explain a little

more. And it's easiest for me to share with them a story or two to demonstrate the importance of the rural hospital nurse.

One year after graduation, I find myself working nights at a small rural hospital. After a year on the telemetry floor at St. Francis Hospital in La Crosse, I consider myself a seasoned cardiac nurse. I can read rhythm strips, identify chest pain and heart attack signs, and treat the patient with congestive heart fail-

ure. But when I married and moved to southwestern Wisconsin, I ended up at a local rural hospital. I was comfortable with the cardiac patients, but beyond cardiac, well, I was in trouble. So, I'm on the night shift and the phone rings. The woman calling says that her husband is having pain on the right side of his chest, just under his ribs. What should they do? Of course, I'm thinking cardiac, and she should bring him in. (This was at a time when telephone advice was common and appreciated.) One of the more seasoned nurses signals to let her take the call. I listen and learn. She asks the ques-

tions to better elicit where the pain is. And what precipitated the pain and what made it worse. He'd had French fries and a big greasy cheeseburger right before bedtime. And she identifies that his gall bladder is probably the culprit. She goes on to offer advice about what they can do till the morning. Now, I truly understand how little I know after a year on a specialty unit—and how much this rural hospital nurse knows.

RWHC Eye On Health



"Nurses here are smart and they keep 'community' in 'community hospital.'"

I've been at Lancaster Memorial Hospital for two years, now. I know the nurses and doctors. They're my friends, my colleagues, and my mentors. I'm learning, growing. In fact, I'm growing to the tune of 39 weeks of pregnancy. The contractions come every five minutes and Arlys, my OB nurse and LaMaze instructor, grips my right hand, my husband holds my left. When it's time to push, she is my guide and my help. She's there to welcome my first-born son, Nathan. She assists my husband and my doctor, and I feel so blessed to know that she will continue to take care of me and my son for the rest of this shift. She'll be with me tomorrow as I do Nathan's bath for the first time, and the day after when I need help breast feeding. And she'll be there in the weeks and months to come, when I need advice about the thrush in Nathan's mouth and his diaper rash and my postpartum fever. Only in this small rural hospital could I have a LaMaze instructor, OB coach and ongoing resource all bundled into one fellow nurse. A nurse that I can call at a moment's notice.



probably a kidney stone. Can I get the IV started on this man? Of course I can. In less than 10 minutes, I have the IV in and the Morphine given, all in the time it would have taken him to get through the registration process in the larger hospitals. Later, Jackie takes me aside. "I'm so glad it was you here. He didn't want to come in. But even he said that he felt so much better to see someone he knew. Thank you so much."

That's the thing about the small rural hospital. You'll take care of people you know. Some people will say that's bad. That's hard. They could never do it. But, of course you can do it. And sometimes it's better when you do.

It's another night shift, 17 years later. I usually work days now, but picked up this night shift for one of the new nurses. Her fiancée's birthday. It's been quiet all night. And at 3:00 a.m., I'm so sleepy I can barely keep my eyes open. The ER doorbell buzzes and I rush over. Two bloody teens at the entrance. "We rolled the car. Not bad, but he cut his head." By the time I get them in the door, I realize that the blood is just from one head wound. Josh has a gash in the back of his skull that's about 3 inches long. After they're assessed, blood cleaned up, registered by the admission staff, and seen by the doc, I have to call the sheriff's department. I really don't want to. These two young men are classmates of my son. And there's alcohol involved. I don't want to be the one to make this call—not to mention the one that follows. The call to their parents. I'm not close to Josh's mom, but I worry about being the one to break the news to her. Why did I stay at this small rural hospital? Wouldn't it be better if she could hear this news from a stranger? Wouldn't it? Two hours later, the words spoken were the same as Jackie's. "Pam, I'm so glad it was you. I'm so glad you were here for them, and for us." No embarrassment at their situation. Just relief. And I thank heavens I chose this rural hospital. I'm glad I was here tonight.

Another significant advantage of working in a small rural hospital is the opportunity for the nurse to work so many different departments. As a nurse with 20 years experience, I work ER, Med-Surg, Outpatients and Cardiac Rehab. Playing a role in multiple de-

The **Rural Wisconsin Health Cooperative (RWHC)** was begun in 1979 as a catalyst for regional collaboration, an aggressive and creative force on behalf of rural health and communities. RWHC promotes the preservation and furthers the development of a coordinated system of health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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partments means we can communicate our services more clearly to the patients that need them.

I find myself in cardiac rehab on a Wednesday, scheduled to do the admission assessment for Jim—an MI patient (he'd had a heart attack), who also had bypass surgery in Madison. I smile, remembering...

Jim comes through the ER door with his wife. He's had chest pains for about 30 minutes now and they won't go away. He's nauseated, dizzy, sweating and his left arm aches all the way to his fingertips. I recognize these as classic heart attack symptoms. So did his wife. But he was only 52. Couldn't be a heart attack, could it? In less than an hour, he's had an EKG, IV started, pain medications administered, lab and X-rays done. I've been with them each step of the way—explaining each intervention—why we need it and what it's for. Now we're starting his thrombolytic therapy—tPA. "It's a clotbuster..." I tell him and his wife as the infusion begins. I sit at his bedside charting while we wait for the helicopter—the first quiet moments we've had since they walked in the door. He'll be enjoying a flight to Madison this afternoon, and probably cardiac surgery this week. His wife tells me "this wasn't exactly on his 'honey-do' list this week." And we're all silent for a moment... the unspoken realization that he might not have been there this week—if he hadn't come to the ER. I break the silence. "I'm so glad you came here today. And when you get home from Madison, I wanna see you up and moving. You make sure you do all the follow-up. That will mean cardiac rehab where we'll get you exercising again." In the

hour that follows, we package Jim up on the Med Flight cot. His wife kisses him goodbye and we accompany the UW staff to the hospital heliport site. Standing outside the safety boundaries, his wife and I watch as they load Jim in the copter, the blades begin to move, and the helicopter rises into the sky. Veering off, first to the south, and then to the East—on his way to Madison. My arm is around Jim's wife. Our

tears are shared. We've forged a special bond between nurse, patient and family today. One I'll always remember.

So now I'm greeting them again for their cardiac rehab program. It's not a nurse calling Mr. so-and-so to come back. It's a hug and a greeting. Friends. This hardly feels like work—to orient him to the program and teach them what we'll do in cardiac rehab. Only in a small hospital could I have that opportunity to be with them at both ends of the spectrum—the beginning and the end of his cardiac care.

Speaking of endings. Let's talk about death and dying with dignity. It's definitely the most difficult time a nurse shares with her patients. And when we know the family, and the patient, as prominent community members, it's even more challenging. But maybe, even more rewarding. Two cases come to mind.

As I grew up in a town of 200 people, the local bar was also a place to get milkshakes and listen to the jukebox. Joe ran the bar. His wife and my mom were in homemakers together. Everybody knew Joe. And now, 30 some years later, Joe is in our Hospice room, and barely responsive. His wife at his side. And I'm assigned to take care of him this Saturday morning. With trepida-

Thank you, Nurse...

by Pam Myhre, RN, BSN, CDE

"The pain—so strong—is all I know,
Just give me something to make it go...
It starts right here, it seems to move,
Right through my gut, as if to prove...
I'm not in control...
Thank you, nurse... for precious pain relief."

"I dread the news, not this disease,
I must object and say 'no'—Please!
And then you sit and share with me,
Your knowledge, and it sets me free
To LIVE with it, and live it well...
Thank you, nurse... for words of hope."

"The call I never wanted to hear,
The message that one I love so dear,
Is critically hurt and I can't see
Why all this has come to our family...
And yet, you comfort
You share my fear
You are right there—always near
Thank you nurse...for seeing me through...
These long minutes and hours."

"I have no life, I'm feeble—old
My friends—all gone—if truth be told.
I want to live, but I'm ready to die,
So pray for me and please don't cry...
I'm on my path, now...
Thank you, nurse... for death with dignity."

"It's been long months, the time is now,
Can't seem to cope. You show us how...
To grasp a hand, to push, to breathe,
To give each other just what we need...
Welcoming our precious first-born child...
Thank you, nurse...for the gift of new life."

So... you can see...

It's not the shots, the charts, or skills,
It's not the blood sugars, IVs or pills,
It's the moment-by-moment times that I share,
With patients who know that I really do care.
That makes me forever thrilled to hear...
A "thank you, nurse" whispered in my ear.

tion, I review the chart, recognizing that he's been steadily worse through the past several hours. The night nurses report that they've given him pretty significant amounts of morphine and he's starting to have periods of apnea. I knock gently and enter the room. LaVon is sitting there, holding his hands. "They're so dark" she says, pointing to his hands. "And his breathing is really funny. It's like he can't get his breath. He breathes really, really heavy, and then not at all for a little bit." I pull up a chair and sit with her. We talk about his hands, about the decreasing circulation to his extremities called mottling. We talk about his breathing, something called Cheyne-Stokes respirations. I explain that these are part of the dying process. I warn her that he'll have longer periods where he'll stop breathing. But she can call me back in at any time. Once I'm teaching, I forget that it's the people I know. I only know now that it's the people I care about. My patient and family for the day. If he dies today, I will be fortunate to share the process with them. It won't be easy. But I wouldn't trade it for anything.

To this day, when I see LaVon, she greets me with a smile. She's told me so many times how much it meant for her to have me with her that day—the little girl she knew from Bagley—who was their nurse. In our small, rural hospital.

I truly believe this next story could only happen in a small hospital. In a small community. Again in the Hospice room. In the early morning hours, we received a phone call order to admit a gentleman with terminal cancer. His pain wasn't able to be controlled at home any longer. His significant other accompanied him and Kate was their nurse. During the lengthy admission assessment, she elicited the information that this gentleman probably had only a couple days to live. The couple had desperately wanted to be married before he died, but had been unable to get through the paperwork and get him, with his pain, to a minister to accomplish their goal. Kate completed the admission process, started his pain control and left them to some private time. At the nurse's station she pondered their situation, and shared it with the other nurses and social worker. Could they possibly grant this man his dying wish? It almost sounded like Hollywood. But this was Lancaster. And in a small community things can often be accomplished without too many strings attached. Kate's mother, a local lawyer, is also a minister. She placed the call. Could a wedding be done at the hospi-

tal? Could we do it today? In short order, the nursing director was contacted, the hospital CEO was informed, and the process was underway. Kate's mom got the paperwork and made plans to take an extended lunch hour in order to preside over at a wedding in the hospital. Flowers were obtained and the "wife to be" slipped home to get a dress. Family members were already there. And, at 12:30 that day, the couple was married. The gentleman in his hospice bed, his wife at his side. Not a dry eye in the room. Only here—in a small rural hospital—Lancaster.

These stories are the foundation of my beliefs about the value of our small, rural hospitals. The value of the knowledge and experience that a new nurse will gain as he or she starts her career of caring for others. Caring for those we know is a special gift. And when we share that gift, it is nursing at its very, very best.

Private Medicare Plans Taken to Woodshed?

From "CMS: Seven Private Fee-for-Service Plans to Suspend Marketing" by John Reichard, *CQ HealthBeat News*, 6/15/07 at <<http://public.cq.com/>> :

"The Centers for Medicare and Medicaid Services announced late Friday that seven insurers with the lion's share of the Medicare private fee-for-service plan market have agreed to suspend marketing of the plans. The announcement follows hundreds of complaints by Medicare beneficiaries that they were duped or strong-armed by sales agents into joining the plans without understanding how they worked or the restrictions involved. CMS said the plans will be able to resume marketing when the agency certifies they have controls in place to prevent deceptive marketing."

"State insurance regulators joined Senate Aging Committee Chairman Herb Kohl, D-Wis., at a May 16 hearing in saying Medicare officials have failed to properly oversee the marketing of private plans in Medicare, with Kohl revealing the results of a congressional investigation he said turned up 'countless' cases of seniors being preyed upon by unscrupulous insurance agents. Cases cited at the hearing primarily involved private fee-for-service plans, which were added to Medicare as an alternative to HMOs and

other managed care plans that critics feared would increasingly ration care to the elderly.”

“CMS described the agreement as ‘voluntary’ on the part of the seven insurers, and said they will be permitted to continue enrolling members during the marketing suspension. House Ways and Means Health Subcommittee Chairman Pete Stark, D-Calif., termed the agency’s response to marketing abuses by private fee-for-service plans as ‘pathetic.’ ”

“The seven insurers are Humana, United Healthcare, Wellcare, Universal American Financial Corporation, Coventry, Sterling, and Blue Cross/Blue Shield of Tennessee. A total of 1.5 million Medicare beneficiaries are enrolled in private fee-for-service plans, 200,000 of which signed up as a part of company or union retirement health benefit plans. The other 1.3 million are in the individual, ‘non-group’ market — in other words, they signed up on their own. The marketing suspension applies only to the non-group market. The seven insurers have 90 percent of the non-group market, CMS said.”

“Abby Block, director of the CMS Center for Beneficiary Choices, told reporters in an afternoon telephone briefing that CMS received 2,700 complaints between December 2006 and April 2007 about plans in the private health plan side of Medicare, known as Medicare Advantage. The majority of the complaints were about private fee-for-service plans, she said. Other types of Medicare Advantage plans include HMOs and PPOs.”

“Block didn’t blame the companies themselves for the marketing practices, but rather a relative handful of ‘rogue sales agents’ selling their products. Wisconsin Insurance Commissioner Sean Dilweg told the Senate Aging Committee hearing in May that ‘seniors are being told that they can go to any provider without being told that they may only go to a provider that accepts Medicare, and also a provider that has agreed to accept the plan’s payments.’ ”

“To have the suspension lifted, a plan must provide a complete list of sales representatives if requested to do so by CMS and must authorize the agency—if it seeks to do so—to make the list available to state insurance departments. Plans must make calls to new enrollees to make sure they understand the plan rules and want to enroll. Sales reps will have to pass a written test showing their familiarity with Medicare and the product they are selling. Lists of planned sales events provided to CMS must include ‘delegated’ brokers and agents as well as those sponsored by the plan.”

RWHC Eye On Health



“Stark was unimpressed. ‘The administration’s response is to allow private companies to determine which crimes they’ll plead to and which sentences they’ll serve,’ the California Democrat said in a statement. ‘This will do virtually nothing to protect Medicare beneficiaries and is a pathetic attempt to pre-empt congressional action.’ Stark added that the plans are receiving excessively high payments that, as long as they continue, will lead to huge sales commissions that continue to fuel marketing abuses. Stark is widely expected to propose legis-

lation cutting Medicare payments to private fee-for-service plans.”

“Senate Finance Chairman Max Baucus, D-Mont., offered milder criticism. ‘I applaud plans for volunteering a suspension,’ he said. ‘I’d like to see CMS spend less time promoting private coverage and more time figuring out how to regulate the actions of insurers who sell directly to seniors.’ ”

“Karen Ignagni, president of America’s Health Insurance Plans, said the insurance industry is ‘moving immediately’ to put additional protections in place. She said AHIP has asked CMS and the National Association of Insurance Commissioners to develop a uniform reporting mechanism allowing plans to clearly identify brokers and agents selling on behalf of Medicare Advantage plans. ‘Secondly, we have

urged the development of clear guidelines for health plans to report serious broker-agent misconduct to CMS and the states,' she said."

"Others pointed a finger at the growing private health plan presence in Medicare. 'This is a clear acknowledgment that there are health plan abuses throughout the country that are causing many seniors to be enrolled in plans that are unresponsive to their needs,' said Ron Pollack, Exec. Director of Families USA."

Medicare Closing Rural Pharmacies

From "Medicare Payment Delays Cause Community Pharmacies to Close," *Daily Reports*, 6/14/07 at <http://www.kaisernetwork.org> :

"Medicare prescription drug plans can take as long as 45 days to reimburse pharmacies for medications dispensed, and the delays have caused three community pharmacies to close each day since the program began, according to groups that represent community pharmacies, *CongressDaily* reports. According to the National Community Pharmacists Association, delays in reimbursements from Medicare prescription drug plans for medications dispensed have forced community pharmacies on average to open \$700,000 lines of credit, compared with \$250,000 in the month before the program began."

"The number of community pharmacies decreased by 1,152 to 23,348 in 2006, compared with increases of 500 and 150 in 2005 and 2004, respectively, Douglas Hoey, senior vice president and chief operating officer for NCPA, said. Charles Sewell, senior vice president of government affairs for NCPA, said that House Energy and Commerce Committee Chair John Dingell (D-Mich.) and House Ways and Means Committee Chair Charles Rangel (D-N.Y.) have told the group they will seek to address the issue. Rep. Mike McIntyre (D-N.C.) called the problem a 'double whammy' because both community pharmacies and patients, many of whom live in rural and low-income urban areas, are affected."

"In March, Reps. Marion Berry (D-Ark.), Stephanie Herseth Sandlin (D-S.D.), Walter Jones (R-N.C.) and

Roger Wicker (R-Miss.) introduced a bill (HR 1474) that would require Medicare prescription drug plans to reimburse pharmacies within 14 days. The Pharmaceutical Care Management Association, which represents Medicare prescription drug plans, opposes the requirement, which the group maintains would cost Medicare and patients more than \$9 billion over 10 years. PCMA said that members have promised to reimburse pharmacies within 30 days (Edney, *CongressDaily*, 6/14)."

Wisconsin Academy of Rural Medicine

The Wisconsin Academy of Rural Medicine (WARM) is dedicated to improving the supply of physicians in rural Wisconsin and improving the health of rural Wisconsin communities.

WARM is dedicated to improving the supply of physicians in rural Wisconsin and improving the health of rural Wisconsin communities. This comprehensive medical program will:

- Increase the size of the medical school class by 25 students over the next few years
- Provide individualized guidance based on a student's interests
- Integrate public health and population health concepts relevant to rural populations

WARM students will participate in a longitudinal educational curriculum designed to prepare them for rural practice. Extensive clinical training will be provided in rural Wisconsin settings during the third and fourth years of medical school. Training in rural Wisconsin will allow students to learn to address medical issues that are unique to rural areas, and will also give the students the opportunity to appreciate a rural lifestyle. There will also be opportunities for experiences in international settings, as well as Madison, and other areas around the country.

WARM has the unique distinction as being the only rural focused program in the nation that supports a student's pursuit of any specialty, not just family medicine or primary care, as statewide hospitals and

health systems in Wisconsin have identified the need for rural physicians from virtually all specialties.

Frequently Asked Questions

Why should I apply for WARM? WARM is a student-centered program, and students will receive individualized guidance based on their particular areas of interest. WARM students are expected to have direct patient care contact on many different types of cases that will teach them a variety of clinical skills. WARM will prepare students for a career in rural medicine.

Will clinical experiences in the rural setting provide enough training for WARM students to be competitive for residencies? WARM students will have the opportunity to spend time in Madison and other national or international sites for a particular rotation, depending on a student's interest. This will allow the student to remain tied to the rural community while facilitating necessary curricular experiences.

Where will I live during the third and fourth years of medical school? WARM students will only be responsible for the cost of housing in one location. Students will work with site coordinators to find housing options at the regional and rural sites.

Are loan forgiveness opportunities available for rural physicians? There are several federal, state and local program options, specific to rural locations, to assist with loan repayment. Please contact the WI Office of Rural Health for additional information at <<http://www.worh.org>>.

Curriculum: A rural core curriculum will be taught over the course of the four years of training. The rural curriculum will be integrated in the Rural Health Elective, the Rural Health Interest Group meetings, and the rural health educational activities during the third and fourth years of medical school.

- During the first two years of medical school, WARM students will participate in the traditional curriculum in Madison.

SYMPOSIUM FOR POTENTIAL MED SCHOOL APPLICANTS

The 2nd annual Wisconsin Academy for Rural Medicine (WARM) Symposium will be held on Wednesday, August 8, 2007. The event will take place at the University of Wisconsin School of Medicine and Public Health in the Health Sciences Learning Center in Madison.

The Symposium is for a broad array of individuals to learn more about the WARM program and its plans to address the shortage of physicians in rural Wisconsin and improve the health of rural Wisconsin residents. Register online by July 16 at:

<http://www.med.wisc.edu/education/md/warm/symposium.php>

Dr. Roger Strasser, founding Dean of the Northern Ontario School of Medicine, is the keynote speaker. Dr. Strasser has played a valuable role in the development of rural medical education programs in Australia and around the world. Dean Robert Golden, MD, will also address the symposium, and the first group of WARM students will be introduced. The afternoon session will offer a choice of breakout sessions during a "working lunch." See the WARM website for the symposium schedule.

If you know someone who may be interested in applying to the UW Medical School and working in rural Wisconsin, please let them know they are particularly invited to this Symposium.

Contact Alison Klein at alklein2@wisc.edu or 608.263.7082 for more information.

- Students will select electives relevant to rural practice, and will be encouraged to participate in monthly rural interest group meetings and summer externships.
- WARM students will relocate to their regional and rural learning communities during the third and fourth years of medical school—the first group of WARM students will be hosted by Marshfield Clinic and its clinic in Rice Lake beginning in July 2009.
- Future groups of WARM students will be hosted by sites in the La Crosse and Green Bay areas.
- WARM curriculum will be tailored to match a student's career interest, and students will be offered individualized career planning.

For more information, please go to:

<http://www.med.wisc.edu/education/md/warm>

RWHC '06 Rural Health Ambassador Awards

The Rural Wisconsin Health Cooperative (RWHC) has announced their 2007 Rural Health Ambassador Awards to recognize health care employees at RWHC hospitals who have gone above the call of duty in promoting their respective organizations, while making significant contributions to rural health. Fourteen individuals from across the state received awards this year. Each recipient demonstrates a history of fostering positive communication and relations within the hospital's respective service area by: serving on community boards/service organizations; taking advantage of volunteer or public speaking opportunities; and supporting community health activities beyond the scope of the hospital.

Incorporated in 1979, the Rural Wisconsin Health Cooperative receives national recognition as one of the country's earliest and most successful models for networking among rural hospitals. RWHC serves as a catalyst for regional collaboration and as an aggres-

sive, creative force on behalf of rural communities and rural health. Owned and operated by 32 acute, medical-surgical hospitals, RWHC offers its members a wide range of shared services that meet local community health needs, including: staffing, consulting, management, networking and education. The 2007 RWHC

Rural Health Ambassadors are:



RURAL HEALTH CAREERS
WISCONSIN

Baraboo – **T. Rex Flygt, M.D.**

Columbus – **Kristina Lavis**

Dodgeville – **Jill Roethe**

Hillsboro – **Mark Sullivan**

Mauston – **Dolly Fleming**

Medford – **John Strama**

Neillsville – **Candy Marg & Ken Marg**

Prairie du Sac – **Melanie Breunig**

Richland Center – **Marsha Jones**

Stoughton – **Amy Hermes**

Tomah – **Mary Rezin**

Viroqua – **Dan Nelson**

Whitehall – **Reuben Adams, M.D.**

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