

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

## A Call for Rural Graduate Medical Education

From “Director’s Perspectives” by Dr. Byron Crouse at the University of Wisconsin School of Medicine and Public Health in the *Wisconsin Rural Physician Residency Assistance Program Newsletter*, October, 2012:

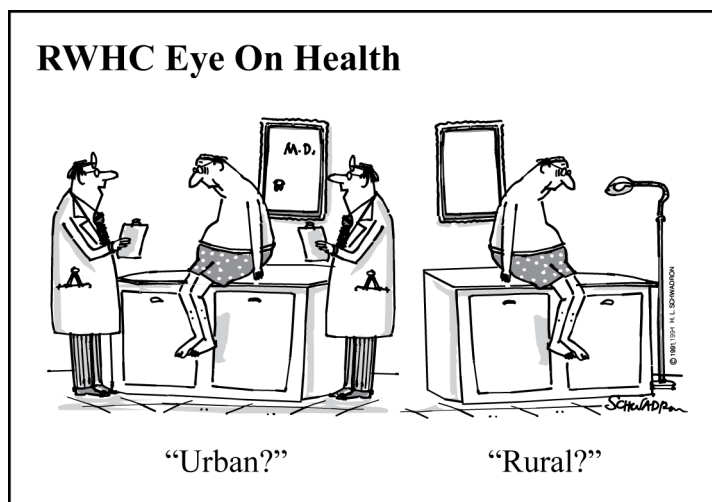
“While the complexity involved in predicting future physician workforce needs make precise predictions unrealistic, there is continued compelling evidence indicating there will be a growing shortage in the future. For the many rural Wisconsin areas currently designated as Health Professional Shortage Areas, the future is now. We know that rural demographics demonstrate that rural populations are older and increasing in number, less likely to be fully insured and have greater social/economic challenges than do urban populations in Wisconsin.”

“These factors, combined with the two-to-three-fold increases in health care services required by those older than 65, magnify the demand for providers in rural areas. While there continues to be debate over the future of health care reform, expanded insurance coverage to reduce the number of uninsured and underinsured individuals in the state is likely and this will also increase demand for more physicians, and again will have a greater impact on rural populations.”

“At the same time, the number of physicians anticipated to retire in the next 5-10 years is significant and some feel that the current economic downturn has delayed some retirements. Time and/or an improved economy will result in a higher retirement rate as delayed retirees join those retiring at a normal time.”

“While the exact number can be debated, it seems clear there will be a growing scarcity of physicians, increasing the current shortages. These combined factors are even more striking in the rural communities of Wisconsin. Programs such as the Wisconsin Academy for Rural Medicine at the University of Wisconsin and the proposed plans at the Medical College of Milwaukee to expand medical student numbers and also focus on

preparing students for rural practice will bring more physicians in training into the ‘pipeline.’ However, if there is no commensurate growth in Graduate Medical Education (GME) positions and no increase in GME focus on education for rural practice, these medical school initiatives will essentially stop at the new training choke hold—GME.”



“The Wisconsin Legislature has responded to the advocacy of the Wisconsin Hospital Association and others and established the Wisconsin Rural Physician Residency Assistance Program (WRPRAP). In this newsletter, the success we report in developing rural community resources to expand rural GME through rotations, residency expansion and fellowships represents an exciting response to the Wisconsin rural physician shortage and the opportunity to be part of the

solution. For this response to be fully realized, there will need to be continued growth in the collaboration between existing residency programs and rural community hospitals and clinics. We involved with WRPRAP look forward to promoting this collaboration and working with other health systems to expand rural GME opportunities in Wisconsin.”

---

## Strong MD/DO Recruitment Only a Partial Fix

---

From “Physician Recruiting About to Get Tougher for Rural Hospitals” by John Commins, for *HealthLeaders Media*, 10/12/12:

“When it comes to recruiting physicians, it’s like this: Rural hospitals have to work harder, talk to more candidates, and expect more rejections. Of course, this should come as no surprise to anyone familiar with recruiting clinicians to rural America. And the data backs it up. These concerns are detailed in the *2012 In-House Physician Recruitment Benchmarking* report from the Association of Staff Physician Recruiters.”

“The report suggests that the increased demand for healthcare services, which are expected with the full implementation of the Affordable Care Act, is going to make recruiting doctors even more difficult for rural providers in the coming years. ‘There is no indication whatsoever that rural recruiting is going to get any easier,’ says Shelly Tudor, chair of the ASPR Benchmarking Committee and member-at-large of the ASPR Board of Directors. ‘In fact, the report shows that the cost of recruitment is going up, [which will make it] it is harder for rural healthcare organizations to compete. A clear correlation exists between the facilities’ population size and acceptance rates, with offers from organizations in larger populations much more likely to be accepted than those in smaller populations.’ ”

“The ASPR benchmark shows that interview-to-hire ratios are much lower in urban areas than in rural areas. ‘In lots of respects, the process favors urban providers. Physicians are coming to urban areas and they are looking for jobs, whereas rural providers have to go out and target physicians that are likely to come to

## Overcoming the Challenges of Rural GME

“The industrial pipeline metaphor must be transformed into something more organic, coherent, sustainable and community-anchored. A pipeline that leaks must be replaced with a stream that is self-renewing, replenished by multiple tributaries, and under girded by a rising water table of community support and endowment funding.”

“Rural medical education must be readily adaptable to changing conditions, aligned with the interests of multiple stakeholders, efficiently linked to desired outcomes and workforce needs, self-renewing and less dependent upon external funding.”

“Academic institutions and communities will benefit from a medical education enterprise that is distributed, rooted, and nourished in diverse underserved communities, is inter-professional in nature, and is adapted in scale and scope to the population it serves.”

Source: *Graduate Medical Education for Rural Practice—A Joint Statement of the National Rural Health Association and the American Academy of Family Physicians*, July, 2008

their area,’ Tudor says. ‘Their interview-to-hire ratios are going to be much, much higher. Their sourcing-to-interview ratios are going to be much higher, too, because they have to filter through a lot of people to find the right one who is willing to come in and even look at the opportunity.’ Further hampering rural hospitals’ efforts to attract physicians is the potential distraction of overworked in-house recruiting officers wearing multiple hats. ‘When you get in these rural areas, you are talking about small hospitals and the in-house recruiter might also be responsible for credentialing, and on-boarding, and administrative responsibilities, and any number of other things,’ Tudor says. ‘She may need help identifying candidates just to even look at.’ For both urban and rural hospitals, the ASPR benchmark reaffirms larger nettlesome trends in physician recruitment.”

“Between 2011 and 2012, there was an increase of 18% in positions unfilled. Seven in 10 (71%) of searches are done by hospitals/integrated delivery systems, up 10% from 2011. Referrals and Internet job boards remain atop the sourcing list. However, 12% of candidates contacted hospitals directly through their websites, indicating the importance of an organization’s online presence. Median time-to-fill was 155 across all physician specialties (222 days on average) compared to a median of 120 days (208 days on aver-

age) from 2011. Median time-to-fill for primary care physicians was 151 days compared to 125 days last year. Time-to-fill for advanced practice providers, such as nurse practitioners and primary care physician assistants, was only 90 days for both the 2012 and 2011. A decline can be seen in the number of searches that were filled (51% in 2012 vs. 60% in 2011) and an increase in those that remained open at the end of the year (42% vs. 36% in 2011). Specialties that were least likely to be filled during 2011 were: med-peds, neurosurgery, dermatology, urology, and otorhinolaryngology.”

“Admittedly, the news from the benchmark is downbeat. But let’s not forget that providing healthcare in rural areas has sublime appeals. ‘One of them is satisfaction,’ Tudor says. ‘If you are inclined to that type of work there is a great deal of satisfaction from helping these people and their communities. They tend to be very grateful for the care they get, versus a metro area where we have certain expectations of what a physician should be. People in rural areas tend to be grateful that they even have a physician.’ Rural hospitals can also provide financial incentives to recruit physicians using funding that is made available if they are designated as a healthcare workforce shortage area by the Health Resources Services Administration. ‘That can be a good incentive for someone who



RURAL HEALTH CAREERS  
WISCONSIN

comes out of medical school,’ Tudor says. ‘I spoke with someone the other day who is \$400,000 in debt from her medical school training. So some rural hospitals do have some advantages in that respect, but you still have to find the people who are willing to go out and explore those possibilities.’ ”

---

## Making the Most of All Primary Care Talent

---

From “Nurses Stepping Up to Solve Primary Care Challenges” in *Charting Nursing’s Future, Reports on Policies That Can Transform Patient Care* from the Robert Wood Johnson Foundation, 8/29/12:

“Many of the most prominent participants in the debate over health care reform have promised—or warned—that reform would spark a revolution in the nation’s health care system. While the health reform law will change much, the truth is that many parts of the system have been evolving for quite some time, and the changes are already making their mark.”

“In primary care, economic and demographic pressures have driven innovation. Many such breakthroughs focus on the roles of nurses, many of whom are leading an evolution in the delivery of primary care. Nurse practitioners (NPs) and certified nurse midwives (CNMs), for example, make up a growing portion of the primary care workforce. Meanwhile, RNs and licensed practical nurses (LPNs) are increasingly tracking patients to make sure they get the care they need. In addition, nurses at several levels are managing chronic conditions and coordinating care transitions.”

“Such evolutionary changes are the subject of the latest installment in the *Charting Nursing’s Future* (CNF) series of policy briefs from the Robert Wood Johnson Foundation (RWJF). It explores the policies that support this evolution, and looks at several innovative models that provide patient-centered, coordinated, and cost-effective care by taking advantage of nursing’s strengths.”

“ ‘Given the current trends in physician-based primary care, the development of a robust cadre of advanced-

**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.

Tim Size, RWHC Executive Director & EOH Editor  
880 Independence Lane, Sauk City, WI 53583

[www.RWHC.com](http://www.RWHC.com)



Email [office@rwhc.com](mailto:office@rwhc.com) with *subscribe* on the subject line for a free e-subscription.

practice primary care nurses (and physician assistants) should become a major priority. ... [It] can be achieved at lower cost and in a shorter timeframe than a comparable increase in the number of primary care physicians. ... [Such an increase] might actually contribute to bending the health care inflation curve.’—*The Heritage Foundation, Not Enough Doctors? Too Many? Why States, Not Washington, Must Solve the Problem*, by Roger E. Meyer, MD, 2010.”

**The IOM’s Prescription**—“The Institute of Medicine’s landmark report, *The Future of Nursing: Leading Change, Advancing Health*, both highlighted and encouraged the transformation in nurses’ roles. It notes that, as the largest and most flexible component of the health care workforce, nurses are ‘poised to help bridge the gap between coverage and access, to coordinate increasingly complex care for a wide range of patients, to fulfill their potential as primary care providers to the full extent of their education and training, and to enable the full economic value of their contributions across practice settings to be realized.’ ”

“Indeed, as the CNF brief observes, NPs are the fastest-growing group of primary care providers, with NP students who plan to enter primary care graduating at three times the rate of their medical student counterparts. Moreover, NPs are more likely to practice in remote and rural areas where physicians are sometimes in short supply.”

“The brief spotlights a number of innovative models that ‘redefine nursing roles to extend access, improve care, and contain costs. These models emphasize the care coordination at which nurses excel. They employ inter-professional teams that share responsibility for health outcomes. They exploit information technology to enhance patient communication, track care, and improve clinical decision-making. They change the way care is paid for, and they allow nurses, physicians, and others to practice to the full extent of their knowledge and skills.’ ”

“Among the initiatives highlighted in the brief are programs in Minnesota, Pennsylvania, and Vermont, as well as a national program implemented by the U.S. Department of Veterans Affairs.”

## The Economic Value of Rural Health Care

From “Economic Impact of Rural Health Care” by Gerald A. Doeksen, Cheryl F. St. Clair, and Fred C. Eilrich at the National Center for Rural Health Works, 9/12:

### Rural Health Impact

- Quality rural health services in rural communities are needed to attract business and industry.
- Quality rural health services in rural communities are needed to attract and/or retain retirees.
- On average, fourteen percent of total employment in rural communities is attributed to the health sector.

### Rural Hospital Impact

- A rural hospital is one of the largest employers in a rural economy, typically one of the top two employers.
- Community members appreciate the role that the hospital plays in providing a first line of defense in a medical emergency and working to assure access to primary care at the local level.
- **The total economic impact of a typical critical access hospital is 195 employees and \$8.4 million in payroll.**

### Rural Primary Care Physician Impact

- **One primary care physician in a rural community creates 23 jobs annually.**
- One primary care physician in a rural community generates \$1.0 million in wages, salaries and benefits annually.
- One primary care physician in a rural community generates approximately \$1.8 million in annual total revenue.

### Rural General Surgeon Impact

- **One general surgeon in a rural community creates 26 jobs annually.**
- One general surgeon in a rural community generates \$1.4 million in wages, salaries, and benefits annually.
- One general surgeon in a rural community generates \$2.7 million in total revenues in the local economy.

### Rural Pharmacy Impact

- A rural pharmacist has an average income of \$107,635.
- A rural pharmacy has 10 employees and generates \$0.3 million in annual payroll.
- The total impact of a rural pharmacy is 12 employees and \$0.4 million in annual payroll.

The complete policy brief is available at <http://ow.ly/eqSye>



## Minnesota's HealthPartners Empowers Primary Care Nurses to Serve Patient Needs

“Under a newly installed program at Minnesota-based HealthPartners, a large nonprofit health care organization, nurses are now taking a lead role in primary care. The organization hires NPs, physicians and physician assistants as primary care providers, and also relies on NPs to diagnose and treat some patients via the Internet. Meanwhile, RNs and licensed practical nurses (LPNs) collaborate with these professionals to anticipate patient needs and make sure they have the supports in place to implement care plans successfully.”

“According to the CNF brief, HealthPartners nurses review electronic health records and order lab work prior to patient visits. They also coordinate post-visit and between-visit care, including transitional care following hospitalization. RNs assess ongoing concerns prior to visits with primary care providers and follow up to ensure that patients understand and implement their care plans.”

“The approach has helped HealthPartners provide a standard of care that exceeds state averages as measured by specific quality measures, at a cost 10 percent lower than the state average.”

## Vermont's Blueprint for Health: Community-Based Nurse Care Coordination

“As part of Vermont's ambitious Blueprint for Health program, a broad series of health care reforms, nurse care coordinators in the community now work in clinics and private practices across the state, where they collaborate with social workers, behavioral health counselors and others to transform the delivery of primary care.”

“Nurses often serve as team leaders, and they and other members of the

## RWHC Eye On Health

© 1994 H. L. SCHWADRON



“You're right, with money tight, we need to scrap 'thou shall honor thy trade guild.'”

teams meet with patients to make sure they receive the preventive and coordinated care they need. ‘The teams are allowing people to take care of patients the way they have always wanted to, or in some cases, allowing them to do what they’ve always done without losing their shirts,’ says Blueprint Associate Director Lisa Dusky Watkins, MD.”

“Another important reform: The state changed its nurse practice act to mitigate physician short-

ages by allowing experienced APRNs (advanced practice registered nurses) to engage in solo practice.”

“Early data from the program suggest that the state is on a path to cost containment.”

**“At the VA, Connecting Nurses with Patients**—The U.S. Department of Veterans Affairs (VA) maintains a workforce with the equivalent of 8,500 full-time nurses who provide continuous, coordinated primary care to the nation's veterans, playing multiple roles as part of Patient-Aligned Care Teams (PACTs).”

“Each five-person PACT includes a primary care provider (an NP, physician, or physician assistant), a nurse care manager (an RN), a clinical associate (an LPN or nursing assistant), and a clerical associate. The fifth member of the team is the veteran, who is encouraged to take an active part in making decisions about his or her health.”

“Each veteran has a RN responsible for coordinating care over the long term, in person or via telehealth technology. This continuity of care over an extended period of time, the VA believes, serves to create strong bonds between nurses, patients, and patients' families.”

“Early results show significant reductions in rates of emergency or

## Support NRHA's New Rural Health Foundation

The National Rural Health Association has launched a foundation that will build a permanent endowment to support programs that identify emerging leaders from and for rural communities and will provide them with training and resources to play a lead role in ensuring access to quality health care for rural Americans. Go to <http://ow.ly/ejmLf> to watch a short video from some of the Foundation's founders or to make a donation to NRHA's foundation today.

urgent care visits, and in acute-care hospital admissions, suggesting that the approach is helping improve veterans' health. The VA anticipates significant cost savings as more enrollees move into PACTs."

**"Reimbursement Models a Barrier**—The brief also notes several barriers to the expansion of nurses' primary-care roles. One such barrier is reimbursement systems. According to Clayton M. Christensen, MBA, MPhil, author of the acclaimed 2009 book, *The Innovator's Prescription*, '[R]eimbursement systems currently trap in high-cost venues much care that could be provided in lower-cost, more convenient business models.' He argues that one reason for the high cost of health care is the lack of business-model innovation in the health care industry. Christensen goes on to propose a model that relies on nurses to take primary responsibility in health care practices for the 'straight-forward diagnosis and treatment of generally acute disorders, such as earaches,' and 'the ongoing oversight of chronic diseases, such as diabetes.' "

"The brief touches on insurance innovations that are making it affordable for private practices to implement nurse care management programs, and that appear to be lowering overall costs while improving patient health. The next issue of *Charting Nursing's Future* will explore impediments to the growth of the primary care sector's capacity, including reimbursement mechanisms, and regulatory, policy and financial barriers that make it difficult for nurses to practice to the full extent of their education and training."

The complete brief is at <http://ow.ly/ejklI>

---

## RWHC Credentials Verification Service

---

**Why use a CVO?** Whether you have a very small or large medical staff/network, outsourcing the credentialing process is the most cost effective way to establish a credentials file. RWHC is able to accelerate the verification process with database automation and online verifications that get the job done accurately, completely, and efficiently. You send a name and contact information; we take it from there until the file is complete and sent to you.

**Continuous Monitoring.** RWHC Credentials Verification Service fee includes continuous monitoring (monthly) of Medicare/Medicaid sanctions as well as state licenses and DEA. We notify our clients immediately of all disciplinary actions when they are discovered. RWHC also tracks the expiration of licenses, DEA, boards, and malpractice. Clients can generate their own report for expirables from our secure website.

**RWHC is Expansive and Experienced.** We are a CVO with over 20 years of experience in many states and with all types of healthcare practitioners. RWHC is equipped to handle the credentialing needs of a larger healthcare organization, yet small enough to know our clients as individuals. We can assist you with meeting your Joint Commission or NCQA standards for credentialing.

**RWHC is Different from National CVOs.** We provide a comprehensive service; from mailing the application to sending the complete file to the client. Our fees are inclusive, no unexpected charges for verifications or when multiple requests are needed to obtain a document. There are no monthly volume requirements.

**Satisfaction Guaranteed.** File turnaround time is as important as accuracy and completeness; RWHC completes most files in 30-45 days. File status is always accessible to you via our secure website. If you have a question, you can contact us by phone or email. All staff are knowledgeable about the credentialing process, so our response will be timely and helpful.

**For more information,** please contact Bonnie Laffey at [blaffey@rwhc.com](mailto:blaffey@rwhc.com) or 1-800-225-2531.

---

## Leadership Insights: "To Do: My Best"

---

The following is from the September/October 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 have our SMART goals, online leadership plans, outlook calendars, mobile phone buzzers, random scraps of paper...

However we organize our ‘to-do’ lists, it’s no small pile. In the face of beeping reminders and competing deadlines, we can overwhelm ourselves at times with all there is to do.”

“In Don Miguel Ruiz’s book, *The Four Agreements*, he outlines a simple and accessible philosophy of living that is actually pretty helpful and applicable in managing our work and life. The four agreements he advises us to make with ourselves are:

1. **Do your best**
2. **Don’t take things personally**
3. **Be impeccable with your word**
4. **Don’t make assumptions”**

“In this newsletter, I will focus on the first one: **do your best**. Some days are better than others because we have more strength, insight, and resources of whatever kind, and fewer barriers. Often we struggle though, either beating ourselves up when things don’t turn out as planned, or blaming others for putting up roadblocks. **The challenge is to balance continually striving to do great things while forgiving ourselves or others when our actual performance is not what we hoped for.** The following ideas may help you achieve that balance.”

- **“Just say it.** It *can* be this simple. Say this phrase to yourself frequently: ‘Do Your Best.’ Put it up on your refrigerator at home, on your calendar, or anywhere you can see it regularly. In the middle of an overwhelmed moment, remind yourself to *just do your best*. It won’t shorten your to-do list, but it will free up energy going to unhealthy stress from the other less helpful comments you are making in your head. (*Yes, we all talk to ourselves. Might as well say something useful.*)”
- **“Make use of your mistakes.** Lately I’ve been aware that my workshops have more impact when I

### 21<sup>st</sup> Annual \$2,500 Monato Essay

A \$2,500 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 by April 15th.

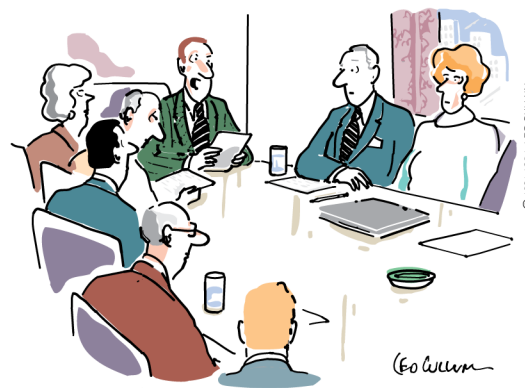
Submission info available at [www.RWHC.com](http://www.RWHC.com)

make a mistake in front of everyone. It’s ironic because 20 years ago, these same ‘mistakes’ would have embarrassed and convinced me that I wasn’t cut out for

this work. Often the very thing we worry most about can turn out to be a gift. People want to see that a leader is human. *What mistakes have turned out to be gifts for you? Are there ways that when you miss the mark it helps others learn? What ‘stories’ do you have that are all the richer because your best effort turned out differently than you planned?”*

- **“Work with your type** to build confidence and increase motivation. Make the most of your natural personality traits and talents you have, where your ‘best’ will shine. For example, one introvert finds that writing and research projects are a great match for his personality. *Where does your work fit your personality, and are you making the most of that?”*
- **“Work against your type** to expand your awareness and stretch. The same introvert pushes himself to participate in customer service initiatives to get out with people and interact in ways that leaders are expected to be skilled at. He’ll admit it doesn’t always feel like his ‘best’ but it’s an opportunity to broaden his skills. ***It’s YOUR best, not the BEST EVER FROM ANYONE that we are talking about.***”

### RWHC Eye On Health



“You’re not doctors. If you’re not making any mistakes, you’re not doing your best.”

- **“Relate vs. compare.** I heard this interesting phrase recently quoted from a Quint Studor piece. When we compare ourselves with others we will always either fall short or feel superior, neither of which helps much when striving for balance and self acceptance (and it doesn’t do much for team building either). Instead of comparing, ask, ‘*How can I relate to this person?*’ It encourages empathy, and when we put ourselves in others shoes, we are less hard on them and ourselves.”
- **“Give up the invulnerability myth.** If you are hanging on to the idea that you must look like you have it all together at all times, tune in to Brene Brown’s TED Talk at <http://ow.ly/eqHDX>. Her research explores wholehearted living requiring:
  - ✓ Courage—to be imperfect
  - ✓ Compassion—to be kind to ourselves first and then to others
  - ✓ Connection—which results from letting go of who we think we ‘should’ be
  - ✓ Vulnerability—willingness to try even if you don’t know how something will turn out”

- **“Rest well.** The book *The Power of Full Engagement* by Jim Loehr and Tony Schwartz shares valuable research that reveals that it is as important to rest as it is to give 100% when you are working. In truth, we are less effective when we don’t build in rest time. Doing our best includes putting resting well on our to-do list.”

Contact Jo Anne Preston for individual or group coaching at [jpreston@rwhc.com](mailto:jpreston@rwhc.com) or 608-644-3261. 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 [cballweg@rwhc.com](mailto:cballweg@rwhc.com) or 608-643-2343.

#### **“BE BOLD 2: Growing Wisconsin’s Talent Pool”**

This just released workforce development study supports two goals long advocated by RWHC for the healthcare workforce: (1) comprehensive supply and demand projections and (2) a comprehensive real-time workforce data warehouse. The complete report is available at [www.competitivewi.com](http://www.competitivewi.com).

Space Intentionally Left Blank For Mailing