

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

Mission Based Dental School—Why Not WI?

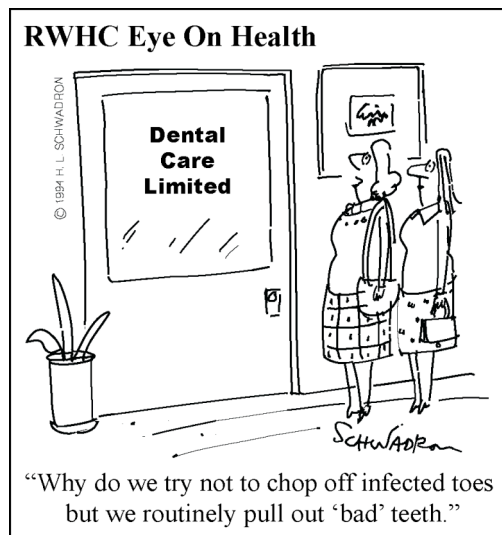
The following is an excerpt from “Jack Dillenberg, DDS, MPH” in the *Community Health Forum*, Issue 7, Number 4, 2006:

“If you ask Jack Dillenberg, DDS, MPH, what one quality sets the students at A.T. Still University (ATSU) in Mesa, Arizona, apart from students at other medical and dental schools across the nation, he will gladly reply, ‘A penchant for community service.’ ”

“As the inaugural dean of the Arizona School of Dentistry and Oral Health (the first dental school in the state), Dr. Dillenberg oversees not only the course curriculum, but also has a hand in selecting potential students. ‘Last year we had about 3,000 applicants to fill 54 slots,’ he says. ‘This year we have more than 3,500. We look for students that have a lot of community service in their background and whose career goals align with the mission of the school. It’s not all about grade point average; it’s about finding caring, compassionate men and women that want to become caring, compassionate health providers.’ ”

“The goal of the dental school, which opened in July 2003, is to train oral health providers to practice in minority and vulnerable population areas, especially American Indian communities. ‘There was a 23 percent vacancy in the Indian Health Services Dental Corps and community health centers weren’t drawing applicants for dentists to serve their populations, so it

was evident something had to change,’ he says. ‘I believe that we can change the profession for the better by changing the people we select. Right now I think we have a profession of good clinicians, but not enough humanitarians. We need good clinicians that are also good humanitarians.’ ”



“Dental students not only receive training in community-based clinical leadership and a Certificate in Public Health, the school offers residency training at community health centers. ‘We involve health centers in the interview process and encourage them to nominate prospective students. **We hope our students will return to their communities armed with the compassion and skills and desire to practice in underserved communities.**’ ”

“In July 2007, five years after the opening of the Arizona School of Dentistry, ATSU will open a similar mission-based medical school. ‘It’s very exciting,’ Dillenberg says. ‘For the first time a dental school has paved the way for a medical school. We have developed an education model that is relevant to the high cost of health care training in a cost-efficient manner. The medical school will follow the same basic principles as the dental school.’ ”

“The goal, Dillenberg explains, is to teach students to focus on the changing definition of primary care and what it means to providers. ‘Primary care is now evolving into prevention and continuity of care. There has been a paradigm shift within primary care to a comprehensive, interdisciplinary model of care. That change is demanding that providers work together

across disciplines, delivering care in a collaborative way.' For example, he says, providers are only beginning to recognize the interconnectedness between oral health and overall health. **'For some reason, we have carved the mouth and the mind out of the body. Science is demanding a new level of thinking to deal with what has become a fragmented, and often dysfunctional, health care system.'** ”

Nycz Inducted into NACHC Hall of Fame



A long-time Wisconsin rural health leader is to be inducted into the National Association of Community Health Clinics Grassroots Hall of Fame. Congratulations to Greg Nycz, Executive Director of Family Health Center of Marshfield. Greg makes the Eveready Battery rabbit look like a

slacker. Members of the Hall of Fame have all made lasting contributions to insure the creation, survival and strength of Health Centers and the Health Center movement through their dedicated and tireless efforts over many years.

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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Not You, Not Me, Tax the Man Behind the Tree

by Tim Size, RWHC Executive Director

When I first heard about a proposal to tax patients at Wisconsin hospitals, I am embarrassed to say I was of two minds. This proposal is formally described as an “assessment” on hospitals but many feel it is more fairly described as a “sick tax.” Whatever label you put on it, it is an additional cost to non-profit hospitals that their patients will pay, either in higher prices or fewer services. At the same time, I know there is an urgent need for additional federal dollars that we only can get if we raise additional in-state dollars.

If I had a rich uncle who offered to give me two dollars for every one I could raise at home, I'd look hard to find a way to do it. In the most recent report available, Wisconsin only gets back \$.82 on each dollar we send to Washington, DC. Compared to other states, we rank 48th in the amount of federal dollars per person that come back to Wisconsin. If you think this isn't so bad because it is due to our lack of receiving federal spending for a 'volatile' defense industry, you'd be wrong; we also rank near the bottom in per capita non-defense funding (42nd). Wisconsin's ranking for the percentage of costs paid to hospitals in its Medicaid program is similarly at the bottom.

I plan to grow very old in Wisconsin so I need our state to invest in its future, not to take me along in a race to the bottom. As a state we have been slipping in our ranking compared to other states in average income, percent of kids graduating from high school, percent of college graduates staying in Wisconsin, dollars invested in startup companies and many other important indicators of our economic and social competitiveness.

But I also know about Wisconsin's non-profit nursing homes' experience with a similar provider tax; it is not a pretty picture. According to John Sauer, executive director of the state association of non-profit nursing homes, they pay more in tax than they get back in increased reimbursement. “Once you embrace the position of taxing the provider community to leverage additional federal money in matching funds, this becomes the first option for funding future

increases and dollars are often siphoned off for other state spending,” Sauer said.

The proposed tax on patients is not even close to being equitable. Bottom line, hospitals make lousy tax collectors as a large share of our patients are on government programs and often exempt from our ability to collect the tax, leaving those not exempt to pick up the entire assessment, regardless of their income.

For example, if two-thirds of a hospital's patients are exempt, a one percent “assessment” on the hospital's total revenue becomes a three percent tax on the remaining one-third of its patients who are not exempt. As this is more likely to fall on lower income working families with less comprehensive insurance coverage, this tax is regressive—strongly at odds with Wisconsin's progressive tradition.

I don't envy the Governor and the Legislature's job of addressing a complex array of competing priorities that have to be brought together this summer into a balanced budget. I believe hospitals have shown restraint when they criticize the tax but not the tax collectors or the need for taxes. This comes naturally as most hospital executives are necessarily schizophrenic when it comes to politics, loving the Democrat's preference to support health care and the Republican's preference not to over regulate it.

To do otherwise would make little sense for a sector that is so dependent on public funding that one way or the other must be paid for by taxes. The late and venerable Senator Russell Long of Louisiana said it best, “don't tax you, don't tax me, tax that man behind the tree” and may have also said “don't cut my program, cut that one hiding over there.”

There is no easy solution, but one place to start is to focus on the problem not the rhetoric. How do we raise the match needed to increase the amount of federal dollars coming into Wisconsin? How can hospitals in their role as hospitals best contribute to our state's competitiveness? A good place to start is to use a higher cigarette tax as the required match for

additional federal funds to help pay for the enormous expense of smoking related illness.

I don't know the whole answer, but it's not forcing non-profit hospitals to tax their patients.

Physician Shortage Slams Rural Economy

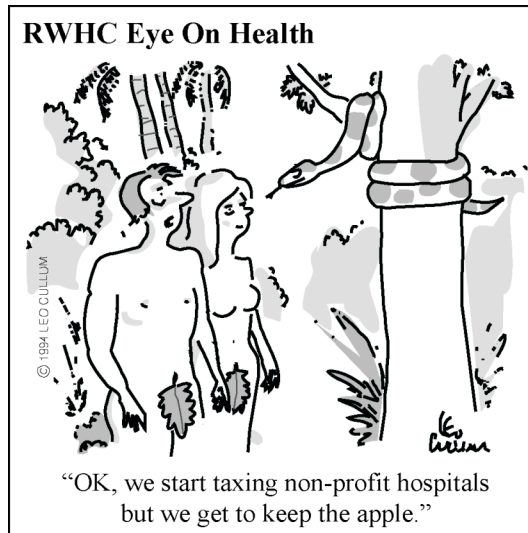
The following is from “The Economic Impact of a Rural Primary Care Physician and the Potential Health Dollars Lost to Out-migrating Health Services” by

Fred Eilrich, Gerald Doeksen and Cheryl St. Clair at the National Center for Rural Health Works, Oklahoma State University. The complete article is available at www.ruralhealthworks.org and then clicking on “#6 New RHW Applications.”

“The importance of a local physician and the medical contribution that he or she makes to the community can easily be revealed with improvements in residents' health and higher qual-

ity of life indicators. However, the economic contribution is not typically quantified. This study clearly demonstrates that economic contributions are as important as medical contributions. A rural physician generates about \$1.5 million in revenue, \$0.9 million in payroll (wages, salaries and benefits) and creates local jobs. These effects are underestimated as the impact on the local pharmacy is not included.”

“When expenditures are being lost due to residents utilizing physicians or hospitals outside the community, the lost dollars can be significant. The actual amount of lost dollars was estimated for a theoretical rural community. **The results revealed that even if there was a 0.6 primary care physician shortage, the community would be missing an estimated \$236,565 from the physician clinic visits and the hospital would be losing \$451,169 net revenue that could be gained from inpatient services and outpatient activity.** After adjusting for indirect and induced effect with economic multipliers, the total im-



pact of this 0.6 physician shortage was 13.8 jobs and \$533,493 in income.”

“The lost income also has a negative impact on potential sales tax collections which affects a community’s ability to fund other important services. Finally, in addition to missed revenues from the lack of certain specialty physicians, the community is not capturing all of its potential expenditures on laboratory services as patients tend to have laboratory work done at the specialist’s location.”

“The methodologies used in this study can serve as tools for community leaders to assess their local health services in terms of primary care physician visits. The results can serve as templates to identify potential health expenditures that might be recaptured with additional physicians or by introducing specialists to the area. All recaptured dollars can be regarded as new revenue that comes into the community. New revenues stimulate growth and economic development and are further amplified by the multiplier effect that comes with them. Local decision makers should exercise caution when estimating local spending, particularly when utilizing national coefficients that are implemented in this study.”

“Spending patterns and income levels vary across regions and from state to state. Available local data should be utilized to improve accuracy. However, in the absence of local data, these national coefficients serve as valuable estimators of potential health expenditures which could result in increased local revenues. The process of determining a local community’s economic potential from health care services may expose issues that can and should be addressed as well as providing an avenue to potentially increase the community’s economic health.”

Primary Care Income Gap Driving Shortage

From “The Primary Care–Specialty Income Gap: Why It Matters” by Thomas Bodenheimer, MD; Robert Berenson, MD, and Paul Rudolf, MD, JD, in the *Annals of Intern Medicine*, February, 2007:

“A large, widening gap exists between the incomes of primary care physicians and those of many specialists. This disparity is important because noncompetitive primary care incomes discourage medical school graduates from choosing primary care careers.”

“The Resource-Based Relative Value Scale, designed to reduce the inequality between fees for office visits and payment for procedures, failed to prevent the widening primary care–specialty income gap for 4 reasons: 1) The volume of diagnostic and imaging procedures has increased far more rapidly than the volume of office visits, which benefits specialists who perform those procedures; 2) the process of updating fees every 5 years is heavily influenced by the Relative Value Scale Update Committee, which is composed mainly of specialists; 3) Medicare’s formula for controlling physician payments penalizes primary care physicians; and 4) private insurers tend to pay for procedures, but not for office visits, at higher levels than those paid by Medicare. **Payment reform is essential to guarantee a healthy primary care base to the U.S. health care system.** Incomes of primary care physicians are well below those of many specialists, and the primary care–specialty income gap is widening.”

“According to surveys done by the Medical Group Management Association, median physician income for all primary care increased by 9.9% from 2000 to 2004, compared with a 15.8% increase for all non–primary care specialties. During those years, median income for family practice physicians increased 7.5% to \$156,000, median income for invasive cardiologists increased 16.9% to \$428,000, median income for hematologists and oncologists increased 35.6% to \$350,000, and median income for diagnostic radiologists increased 36.2% to \$407,000. Two other sources, *Medical Economics* and the Center for Studying Health System Change, confirm these trends. The income disparity is not explained by a difference in hours worked per week. Fifteen percent of full-time family practice physicians earned less than \$100,000 in 2004, whereas 20% of invasive cardiologists, 25% of neurosurgeons, and 14% of orthopedists had incomes of \$600,000 or more.”

“Does this income gap matter? Yes. Although incomes of primary care physicians are far higher than



RURAL HEALTH CAREERS
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the earnings of most persons in the United States, and the public has little sympathy for physicians who cry poor, the lower income of primary care physicians is a major factor leading U.S. medical students to reject primary care careers. **The percentage of U.S. medical graduates choosing family medicine decreased from 14% in 2000 to 8% in 2005.** Seventy-five percent of internal medicine residents eventually become subspecialists or hospitalists rather than general internists. Because office visit fees are relatively low, primary care physicians schedule many short, rushed visits to keep afloat financially, which potentially compromises patient outcomes and fosters the unsustainable physician work life that contributes to students' avoidance of primary care careers. With a median debt of \$120,000 for public and \$160,000 for private medical schools, medical students are further discouraged from choosing careers in primary because of the noncompetitive income."

Rural Development Must Punch Holes in Silos

From testimony by Charles W. Fluharty, President, Rural Policy Research Institute at the University of Missouri-Columbia before the United States Senate Committee on Agriculture, Nutrition and Forestry, Washington, DC, February 13th, 2007:

"A new rural entrepreneurial culture and climate has emerged, but must be nurtured and scaled. Rural economic development must overcome a number of obvious challenges. Low population size and density, and limited local demand make it difficult to achieve economies of scale. Efforts to achieve efficiencies drive consolidation, from school systems to financial institutions, often with unintended but very deleterious consequences."

"Remoteness from global markets and poor infrastructure limits rural economic opportunities, and core connections to regional and global markets exacerbate these challenges. More poorly educated, lower skilled workers and the challenges of building rural entrepreneurial cultures have limited rural participation in the new global economy. However, across the nation today, a new rural entrepreneurial culture and climate is flourishing."

"Philanthropy is playing a significant role in these developments, but more must be done, and systemic change will only be achieved if integrative, long-term investments and programs can be coordinated and sustained. Four principles should drive these efforts."

- **Focus on the entrepreneur.** "Systems thinking is required to properly organize and align the training, technical assistance, and financing programs that are available for small businesses and entrepreneurs. Focusing on the entrepreneurs and their needs ensures that all these programs are aligned in a coherent system, that allows entrepreneurs to obtain the support they need without being passed from door to door or given inappropriate advice."
- **Focus on the region.** "Only through *regional co-operation across jurisdictions and through regionally-aware institutions* can there be sufficient scale, resources, and expertise to enable individual communities to play their full role as supporters of an entrepreneurial climate. It is rare for an individual county to be able to act effectively on its own in economic development, workforce development, transportation or any other complex public service activity. Economic regions invariably cross county and often state boundaries, and these boundaries are irrelevant for the markets entrepreneurs have to be able to serve."
- **Focus on the community.** "Local communities need the tools and resources to identify and build upon their competitive assets, and to make appropriate choices among economic, social, and environmental imperatives. Communities can achieve much if they are open to experimentation and innovation, but they will go nowhere if they continue to do what they have been doing for decades, in spite of the changes that are going on around them."
- **Focus on continuous learning.** "Entrepreneurs, policymakers, community leaders, and service providers all benefit from networks of peer support and learning. Entrepreneurs in particular rely on networks to share ideas, conduct business together, and link to markets, capital, employees, partners, and services. Taking this one step further, entrepreneurship should without a doubt be an integral part of the school curriculum."

“If we are to achieve this, three steps are essential. First, anchor institutions with the capacity to articulate a vision, advocate for change, build partnerships and attract and mobilize resources must be built. Secondly, supportive public policies which ensure adequate resources, send positive messages, and build programs with the capacity and flexibility to meet the needs of diverse rural regions must be crafted. Finally, these approaches must provide support and encouragement to both ‘opportunity’ and ‘necessity’ entrepreneurs, and avoid ‘picking winners.’ We must acknowledge that failures will occur.”

National Rural Health Association
30th Annual Conference: May 16-18, 2007
ANCHORAGE, ALASKA
<http://nrharural.org/>

“The most recent listing of Core Based Statistical Areas for the United States and Puerto Rico (December 2005) by the Office of Management and Budget includes

369 Metropolitan Statistical Areas (361 in the U.S. and 8 in Puerto Rico), and 582 Micropolitan Statistical Areas (577 in the U.S. and 5 in Puerto Rico). Metropolitan and micropolitan areas may contain one or many counties, and many cross state lines.”

“Nonmetropolitan counties, which include both micropolitan and noncore counties, are often equated with rural. However, official definitions of rural and urban involve sub-county geography. Urban areas are defined by the U.S. Census Bureau as ‘core census block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile.’ All territory not defined as urban is considered rural. Urban areas are divided into two categories: urbanized areas have populations of 50,000 or more, and urban clusters have populations from 2,500 to 49,999.”

“Both metropolitan and nonmetropolitan counties contain both urban and rural territory. *Over half of all rural people actually reside in metropolitan counties. And, over 40 million metropolitan residents reside outside of large urbanized areas.* It is important, then, to look beyond county level designations when targeting rural populations in public policy and program design.”

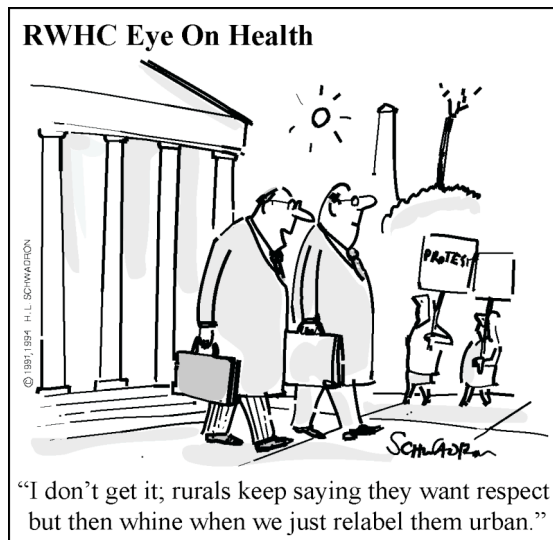
“Clearly, nonmetropolitan residents should be included when targeting rural populations. While nonmetropolitan counties do include some urban residents, with few exceptions nonmetropolitan urban residents live in small cities and towns, which are not targeted in urban programs. Though unintentional, urban targeting tends to usually advantage larger urbanized areas, while many smaller cities and towns, as well as rural populations within metropolitan counties, often fail to receive significant advantage from urban programs; and likewise are excluded

Rural Lost in Complex Federal Designations

Also from testimony by Charles W. Fluharty, President, Rural Policy Research Institute at the University of Missouri-Columbia before the United States Senate Committee on Agriculture, Nutrition and Forestry, Washington, DC, February 13th, 2007:

“New rural policy and program targeting must address the emerging interdependence of rural and urban people and places, and to build new alliances across these constituencies.”

“County level designations of metropolitan, micropolitan and noncore areas, collectively referred to as core based statistical areas, are often used in federal program targeting. Metropolitan areas are defined by the presence of a principal city of at least 50,000 population, plus surrounding counties that are linked to it through commuting ties. Micropolitan areas contain a principal city of 10,000 to 49,999 plus surrounding counties that are linked to it through commuting ties. All other counties not included in metropolitan or micropolitan areas are defined as noncore counties.”



from rural programs which target only nonmetropolitan residents. Given these dynamics, and the level of rural population in metropolitan areas, policymakers should consider new alternatives for precise rural targeting.”

Questions Are the Answer

From “Five Steps to Safer Health Care,” more info at [<http://www.ahrq.gov/questionsaretheanswer/>](http://www.ahrq.gov/questionsaretheanswer/) :

“This fact sheet tells what you can do to get safer health care. It was developed by the U.S. Department of Health and Human Services in partnership with the American Hospital Association and the American Medical Association. These are the Five Steps:

1. **Ask questions if you have doubts or concerns.** Ask questions and make sure you understand the answers. Choose a doctor you feel comfortable talking to. Take a relative/friend with you to help you ask questions and understand the answers.

Do You Know the Right Questions to Ask?

- What is the test for?
- How many times have you done this?
- When will I get the results?
- Why do I need this surgery?
- Are there any alternatives to surgery?
- What are the possible complications?
- Which hospital is best for my needs?
- How do you spell the name of that drug?
- Are there any side effects?
- Will this medicine interact with medicines that I’m already taking?

Cut Out & Take These Questions With You.

2. **Keep and bring a list of ALL the medicines you take.** Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines. Tell them about any drug allergies you have. Ask about side effects and what to avoid while taking the medicine. Read the label when you get your medicine, including all warnings. Make sure your medicine is what the doctor ordered and know how to use it. Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.** Ask when and how you will get the results of tests or procedures. Don’t assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail. Call your doctor and ask for your results. Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.** Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from. Be sure you understand the instructions you get about followup care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.** Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation. Ask your doctor, ‘Who will manage my care when I am in the hospital?’ Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after the surgery?
 - How can I expect to feel during recovery?
 - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.”

WI Health Careers 2007 Summer Camps

Health Careers Camps are five day programs held around the state of Wisconsin, targeted for those who will be entering grades 9-12. These camps allow the students to experience first hand the challenges, opportunities and rewards of health professions. The hands-on activities are facilitated by health profession students, instructors and health care professionals. Diversity awareness and leadership skill training are also a part of the camp experience.

This unique camp is a collaboration of Wisconsin AHEC regional offices, local colleges, technical schools, and area healthcare practitioners. These summer camps are open to any student in high school. Meals, lodging expenses and other program costs are provided by AHEC funding and sponsoring organizations. Chaperones will be on site at all times. A nonrefundable \$40-45 reservation fee is required upon acceptance to a camp. There are scholarships available.

College students interested in chaperoning at any of the camps should apply using the separate HCC counselor application. Pay will vary, depending upon the camp. Please send your application to the contact listed for the camp where you are interested in working. Camper and counselor applications are available for the regional camps by calling (608) 263-1712 or going to <<http://www.ahec.wisc.edu/>>.

- Southwest WI AHEC - Madison camp
- Southwest WI AHEC - LaCrosse camp
- Northeastern WI AHEC - Sheboygan area camp
- Northeastern WI AHEC - Fox Valley area camp
- Milwaukee AHEC - Milwaukee area camp

**RWHC Rural Health Essay Competition
15th Annual \$1,000 Prize - April 15 Deadline**

The Hermes Monato, Jr. Prize of \$1,000 is awarded annually for the best rural health paper. It is open to all students of the University of Wisconsin. Previous award winners, judging criteria and submission information are available at <www.rwhc.com/Awards/MonatoPrize.aspx>.

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