

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

Local Clusters of Self-Reliance

The following is a posting from “Small Mart,” a blog by Michael Shuman entitled “Local Clusters of Self-Reliance: The Key to Rural Prosperity,” 3/13/09. Michael is Director of Research and Public Policy for the Business Alliance for Local Living Economies (BALLE), and author of *The Small-Mart Revolution: How Local Businesses Are Beating the Global Competition* (Berrett-Koehler, 2007):

“At a time when daily headlines bring worse and worse news about the plight of rural economies, it’s worth reminding ourselves that success is possible.”

“Last autumn, Marian Burros of the *New York Times* wrote a piece about how the 3000-person community of Hardwick, Vermont, has prospered by creating a new ‘economic cluster’ around local food. Cutting-edge restaurants, artisan cheese makers, and organic orchardists turning fruit into exquisite pies are just some of the new businesses that have added an estimated 75-100 jobs to the area in recent years. A new Vermont Food Venture Center hopes to accelerate this creation of enterprises.”

“Fifteen years ago, Güssing was a dying rural community of 4,000 in Austria. Its old industries of logging and farming had been demolished by global competi-

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tion. Many of today’s economic developers would have given up and encouraged the residents to move elsewhere. But the mayor of Güssing decided that the key to prosperity was to plug energy ‘leaks.’ He built a small district heating system, fueled with local wood. The local money saved by importing less energy was then reinvested in expanding the district-heating system and in new energy business.

Since then, 50 new firms have opened, creating 1,000 new jobs. And most remarkably, the town estimates that this economic expansion actually will result in a *reduction* of its carbon footprint by 90%.”

“These two case examples cast doubt on one of the principal prescriptions for rural communities given by economic developers—that rural communities should focus on expanding *existing* clusters of export-oriented business. Under this formula, much of rural America

is destined to destitution, because the powerful forces of globalization are eclipsing their existing natural resource industries like farming, ranching, for-

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“Not really a tough question: grow the local economy by using local services or export your own job.”

stry, mining, and fishing. This, in a nutshell, is why rural communities should tell economic developers to take a nice long vacation while they do exactly the opposite: create new, import-substituting clusters.”

“**Rural Clusteritis**—Ever since Michael Porter wrote *The Competitive Advantage of Nations* in 1990, economic developers have had a debilitating case of *clusteritis*. Here’s the basic idea: Inventory the businesses in your economy, identify concentrations of similar ones (like fishing, if you’re a typical coastal town), figure out your global competitive advantage (maybe salmon or crab), and focus your development efforts on expanding those clusters (perhaps a frozen crab-cake manufacturer). The reason for building clusters, Porter argued, is that a critical mass of similar industry people tends to spur healthy competition, fire up innovation, and spawn new businesses within the cluster.”

“In a diversified city or regional economy, this theory is helpful. But it’s overused. And unless combined with other small-mart ideas, such as maximizing local ownership and reinvesting cluster-produced wealth in the weaker sectors in the economy, it can wind up providing the public sector a convenient excuse to subsidize the richest (and least worthy) businesses in town. But in principle, it is still a useful tool.”

“In the rural context, however, clusteritis can be deadly. One of the central problems of a typical rural economy is the absence of diversification. So trying to sharpen a small town’s one competitive advantage sets it up for a huge bust when that one global market

contracts, shifts, or disappears. Every paper-company town knows that when the big mill shuts down (or moves to Siberia), no matter how many other businesses were created in that cluster, the local economy plunges into a death spiral.”

“A rural community actually needs to *avoid* focusing on existing clusters. It needs to develop multiple new business sectors that expand the local skill base, increase entrepreneurship, and reduce the town’s vulnerability to those inevitable ups and downs in global markets. It needs, in short, to develop *new* clusters.”

“**The Importance of New Rural Clusters**—Both the Hardwick and Güssing examples demonstrate that substituting homegrown business for imports does not mean delinking from the global economy. In fact, it’s just the opposite. By focusing first and foremost on local demands for food and energy, and by creating cutting-edge businesses to meet these demands, both communities were naturally able to grow new, powerful export-oriented industries. As Jane Jacobs argued in *Cities and the Wealth of Nations*, import-replacement is, paradoxically, the key to a community competing effectively in the global economy.”

“In both the Hardwick and Güssing examples, the leadership for the import-substitution effort came from a smart core of public employees. In fact, even a single, visionary business can take the lead. Take Zingerman’s in Ann Arbor, Michigan.”

“On its first day of business in a college town known globally more for its radicalism than for its food, Zingerman’s Deli sold about \$100 worth of sandwiches. That was 1982. It has since grown into a community of businesses, each independent but linked through overlapping partnerships that collectively employ 525 people and achieve annual sales of over \$27 million. One way of thinking about this story is that the proprietors conscientiously built a food cluster from scratch. They carefully assessed the items going into the deli – bread, coffee, cheeses – and saw profitable opportunities for creating a bakery, a coffee roaster, and a creamery. They looked at the products being sold at the deli – fabulous coffee cakes and high-quality meats – and built new, value-adding businesses with these products, including a mail-order company and a restaurant called the Roadhouse. They are now creating a brewery, a pub-

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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lishing company, and a hotel. Their model has been so successful that they created a consulting firm to meet the demand for advice and technical assistance from entrepreneurs and communities worldwide.”

“What each of these examples underscores is that there are plenty of cost-effective opportunities for growing business, based initially on local sales. Forget about high tech, biotech, nanotech. If you’re a smart rural community, start with what your residents are already spending their money on.”

“Identify and Address Common Rural ‘Leaks’—Over the past decade, I’ve done ‘leakage studies’ for a half dozen communities, most of them rural. The purpose is to identify all those sectors in the economy where a community is unnecessarily importing goods and services. Every unnecessary import represents a loss of dollars and a loss of the ‘multiplier’ impacts those dollars could have locally. It also represents a loss of other documented benefits local business brings, like knowledge, skills, tax payments, charitable giving, revitalized downtowns, tourists, stronger civil society, and more political participation.”

“What’s striking is how many of the same ‘leakages’ appear over and over again in rural communities. More work is needed to generalize this case with academic ‘rigor,’ but allow me to share some of the obvious clusters, beyond food and energy, where reduction of leakage is a no-brainer:”

“Finance—We have long known that local banks and credit unions have lower overheads, lower default rates, higher interest rates on savings, and lower fees on checking. Now we can add that these institutions also appear to be much less likely to engage in predatory lending and global securitization, and therefore are much less prone to the spectacular collapses we’ve seen in recent months. Finance, of course, is closely tied with two of the largest expenditures rural residents make—or shelter and transportation. Put another way, localize your finance and this allows you to localize your spending on housing (typically the largest item in a family budget) and localize about half your car spending.”

“Services—Two-thirds of the budget in every U.S. household involves some kind of service, whether health care, education, lawn clipping, auto repair, or

accounting. Most services are inherently local and can be competitively delivered by professionals working out of their homes (the real and largely unappreciated ‘industrial development parks’ in rural areas). Rural communities have all kinds of service gaps that lead residents to travel elsewhere. A great strategy for rural development is to identify these gaps, encourage existing service providers to expand into these areas, and target entrepreneurship efforts on creating these kinds of professionals.”

“Entertainment—One of the biggest gaps in rural communities is, frankly, fun. Yet there is no reason why a rural community, or a network of proximate communities, cannot design a year-round calendar of festivals, sporting events, concerts, plays, etc. that display and nurture local art, music, and culture. This is essential for convincing young people, especially the best and brightest, to stick around.”

“Charity—A typical rural household donates more than \$1,000 per year. These donations can and should be given locally.”

“Investment—No one will say anymore, at least with a straight face, that investing in Fortune 500 companies rather than local small businesses is the best strategy for getting a high rate of return. Outdated securities laws, however, prevent the development of local investment instruments and local stock exchanges. If these laws are overhauled, which will cost states nothing except legislative time, much of our pension and insurance money can begin to stay local.”

“Healthy Lifestyles—Many of the remaining expenditures on outside goods and services can end with things we could be encouraging locally. If more rural residents walk or bicycle (and more rural governments rethink their zoning to encourage smart, walkable communities), they will drive their nonlocal cars less. Kicking the nonlocal tobacco habit means less need for nonlocal respirators or nonlocal cancer treatments. Eating healthier, local, unprocessed food means less obesity and diabetes, thus fewer visits to the nonlocal hospitals and surgery clinics.”

“Green Markets—Rural Americans are experts at the environmental adage that all waste should be food. That is, organic waste should become compost, paper and metal waste should be recycled, old vehicles

should be harvested for their parts, broken electronics should be refurbished. To be sure, the current economic downturn has wrecked many of these markets for the moment, but they'll be back. In the meantime..."

“Personal Frugality—In hard times we need to be mindful of everything we buy. Rural economic developers ought to be encouraging residents to buy second-hand clothes, used cars, or rebuilt computers, since these local purchases inject more money into the economy than buying these items new through global dealers and chain stores.”

“As new stimulus funds come into the hands of rural decision makers, they will have a once-in-a-generation opportunity to spend them on the right things. Only by guiding their town to build new clusters of self-reliance, not only in food and energy but in finance, services, health care, even light manufacturing, can they possibly transform the current crisis into renewal and prosperity.”

We Don't Need More Simplistic Solutions

Thanks to Robert C. Bowman, MD, UNMC Department of Family Medicine, Director of Rural Health Education and Research, for the following commentary in response to “We don't need more doctors” by Clayton Christensen, Jason Hwang and Vineeta Vijayaraghavan in a Special to CNN on May 13th:

I almost could buy the argument that if doctors were more productive, then we would not need more doctors. But technology is not going to rescue a nation that has forgotten our need for basic infrastructure needs in health, education, economics and community development.

It follows that if we continue to eliminate the most productive types of clinicians such as family practice physicians and physician assistants, then we will have lower productivity, higher cost, and more need for hospital, emergent, urgent, and specialty care.

This lesson is being re-learned as osteopathic graduates, who were once 55% family physicians, with an

incredibly higher degree of contact with patients see this advantage melting away with a declining number of osteopathic graduates going into Family Medicine.

The authors of “We don't need more doctors” cite as a role model the largest chain of retail clinics which “records average patient satisfaction scores of 4.9 out of 5, while providing care that is 32 to 47 percent below the cost of primary care physicians. While the rest of the health care system only delivers about 55 percent of recommended care, their staff demonstrated 99.15 percent adherence to clinical guidelines in a study involving over 50,000 visits.”

Recommended care is important, but the primary focus still needs to be the one on one relationship with the patient. Comparing chain retail clinics to the rest of the health care system is a joke comparison.

Ninety percent of our health care dollars go to 4% of the land area, locations with grossly too many visits and much waste. Meanwhile 65% of the population is found in zip codes with 23% of physicians and only 10% of the resources. These locations absolutely depend on primary care and chain retail clinics will not find the cash, the insurance, and the higher income that it needs to skim the cream off the top. Mostly these areas will have gaps and if they do end up with convenience care, then even less health care will be delivered due to higher cost.

The authors assert that “medical school graduates have overwhelmingly chosen specialty fields because of low professional satisfaction with the work primary care providers are expected to do.”

Not so—pediatricians and geriatricians are the most satisfied, family medicine physicians are satisfied and internal medicine is the least satisfied. Since Internal Medicine has “left the building,” the primary care building, using their experience is not relevant to a general statement about professional satisfaction with the work of primary care.

Medical school graduates avoid permanent primary care choices such as family medicine because they cannot trust health policy to support them, their health care team members, health access facilities, and the lower and middle income and rural populations left out of the health care funding design. Medi-

cal schools are replacing those most likely to choose family medicine and primary care with those least likely. Medical schools are training as far as possible away from those health care careers that emphasize access to care as they ever have done.

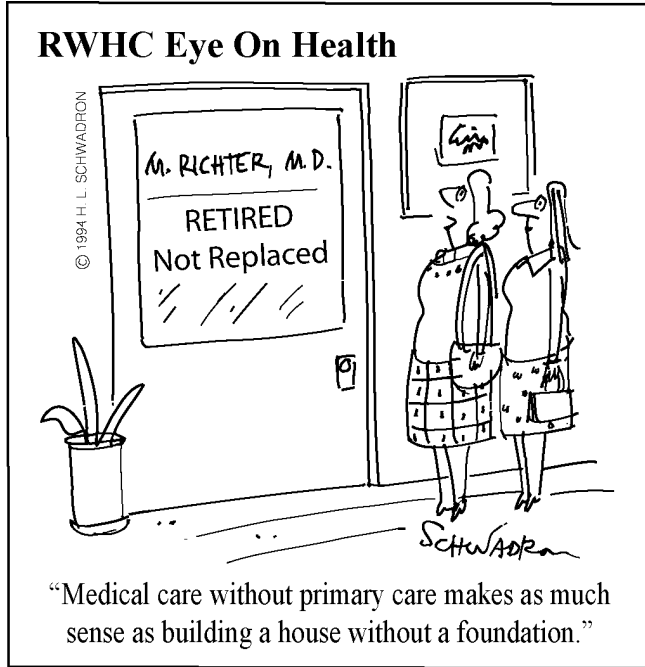
The authors assert that “point-of-care diagnostics allow for diagnoses to be made promptly in the clinic, and easy-to-deploy devices are creating more options for immediate treatment.”

Reducing the most complex health care, primary care, to formulas is far more complex than specialty care and even specialty care cannot be reduced to computer decisions. Peritonsillar abscess, parents who fail to take their child to the ER, abuse, depression, trauma, chest pain, and many more are just a few to consider where the proper course of action involves complexities in interpretation and communication far beyond the ability to express, much less program.

So far more referrals and more cost has been the case with so many “innovations,” not less of either. Optimal health care quality and cost matches up patient to practitioner such that optimal decisions can be made.

The authors assert that “the best solution will not come from increasing the physician supply or introducing salary incentives. Studies of geographical disparities of care have demonstrated that more physicians will likely lead to greater intensity of care—but not better health outcomes.”

When physicians and health resources are grossly inadequate, increases are needed that lead to better quality. The increased cost is justified to have some access to health. Optimal health care cost is first access to care or moving from no access to some. Unfortunately the nation will be moving from some access to none in more and more locations under the current design, especially with these “experts” shaping the nation.



States are already spending 20 - 30 dollars per person on waste such as locums, retention, and recruitment instead of 15 dollars a person on adequate primary care supply with medical school followed by Family Medicine residencies.

The authors should get to a location that has a nice ratio of primary care, continuity care, reasonable balance in economics, sufficient health care coverage, and sufficient physicians. But of course this is only found in 4% of the land area with

90% of health resources and 75% of physicians and most of the NPs and PAs as well.

So as usual the discussion is about what works for a few, rather than 65% left out of the current design and 70% of the elderly and those less mobile, lower and middle income, rural, no health insurance, ridiculous health insurance, those depleted by previous health care costs, those with pensions and health care coverage destroyed, with new additions to the list yearly.

Hard Times in the Heartland

“Throughout rural America, there are 50 million people who face challenges in accessing health care. *Hard Times in the Heartland* <www.healthreform.gov/> provides insight into the current state of health care in rural areas and the critical need for health care reform.”

Health Care and the Rural Economy—“High poverty rates and job loss in the current economic recession highlight the challenges of accessing health care and rising health care costs in rural areas.”

Limited Coverage and Burdensome Costs—“Many rural residents work part-time, seasonally, or for themselves, making them less likely to have private, employer-sponsored health care benefits.”

good focus for this requirement. Vendor capability to produce the CCD should be driven through the CCHIT certification process.”

3. “Quality reporting metrics should be designed to maintain existing data submission efforts and to add those metrics that are relevant to quality and patient safety. Vendor capability to automatically capture and report on relevant statistics should be driven through the CCHIT certification process; but it should be understood that certain data, such as scanned documents or the data captured in physician dictations, will not be machine readable, so automated data capture and reporting will be initially limited. Automated quality submission statistics should be designed with a clear understanding of what will be machine readable after hospitals meet reasonable capability requirements of “meaningful use.” (See section 5). The collection of non-machine readable relevant data should continue through the current abstraction and upload process.”
4. “The primary goals of achieving meaningful use should be improvements in quality and efficiency; however, it should be understood that sometimes quality comes at a higher cost, especially in smaller facilities where there is a lower and sometimes negative return on investment for clinical systems. While we agree that the installation of hardware and software alone is not the primary goal of achieving meaningful use, the migration from paper-based systems to digital systems that allow for decision support and better data collection is in our opinion a required step toward improved quality, as well as for healthcare reform. The critical issue here is to provide enough time for hospitals to phase in certified electronic systems so the hospitals’ existing workflow, quality, and efficiency challenges are mitigated as a result of the implementations.”
5. “Meaningful use capabilities should be clearly defined and phased in over time so they are reasonably attainable and so hospitals can appropriately address vendor selection, preparation, and the workflow and quality challenges discussed above. It should be understood that CAHs and, separately, ‘rural’ hospitals have a median adoption score of 1.1 on the HIMSS EHR adoption model, whereas

‘general medical surgical’ hospitals have a median adoption score of 2.3. Given this, it seems likely to us that if the meaningful use capability thresholds are the same for CAHs and other small rural hospitals as they are for larger hospitals, far fewer small rural hospitals will attain meaningful use and qualify for incentive benefits.”

“This will likely exasperate the existing EHR adoption disparity between large and small hospitals. Also, if small rural hospitals are held to the same threshold standards, it is likely that they will have less time to devote to the workflow and quality aspects and will therefore have a higher rate of failed implementations. To address these issues, we recommend that ‘meaningful use’ thresholds for CAHs and all other small rural hospitals be defined separately from thresholds for hospitals with more than 100 beds.”

“Using the HIMSS phasing recommendation as a template, we recommend the following thresholds for CAHs and all other small rural hospitals with fewer than 100 beds:

Phase 1 (2 years commencing 2011)

“Ancillary department systems (lab, pharmacy, radiology) and a clinical data repository are in use and interfaced to the patient accounting system. Orders and results are available online.”

“A starter set of relevant core measures and other patient safety indicators to become incentivized rather than optional (as they currently are for CAHs). Since most data will still be paper based, continue QI data submissions through the current abstraction and upload process, but allow for automated reporting for the data that is available in machine readable form.”

“Information exchange that is attainable without the need for significant increase in integration and interface expertise in house.”

Phase 2 (2 years commencing 2013)

“Bedside electronic documentation of a variety of clinical information (allergies, care plans, vital signs, flowsheets, inputs and outputs, medication lists, etc.), such as through an electronic nurse documentation sys-

tem. Clinician Prescriber Order Entry and physician documentation are optional.”



through medication contraindication alerts, with CPOE and physician documentation still optional.”

“Expansion of relevant core measures and other patient safety indicators. Incentivized participation in staff and patient perception tools which are currently optional for CAHs. With nurse documentation implemented, expand automation of reporting from the EHR.”

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“Demonstration and reporting of quality improvements relating to the selected indicators, and expansion of indicators to achieve additional patient safety goals.”

“Information exchange that is attainable without the need for significant increase in integration and interface expertise in house.”

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Phase 3 (2 years commencing 2015)

“Important to note that CAH benefit payments phase out after 2015, so this phase is as much to avoid penalties as to gain incentive payments. Prospective Payment Systems (PPS) hospitals that are meaningful users starting in 2013 will be receiving incentive payments through 2016.”

“Electronic Medication Administration Record (eMAR) and clinical decision support, including

Summary–“By phasing in reasonable and achievable requirements, we believe that 5 years from now it will be possible to look back and see significant improvement relating to both EHR adoption and quality for the vast majority of small rural hospitals. If standards are set unreasonably high, without accounting for the current EHR adoption disparity between large and small hospitals, we believe the result will be that a minority of small rural hospitals will achieve the ‘meaningful use’ standards and earn their incentives, while the majority of small rural hospitals will effectively be left behind in the HIT revolution that ARRA represents.”

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