

Review & Commentary on Health Policy Issues for a Rural Perspective – March 1st, 2013

Federal Policy Undermines Rural Medicine

From “The Redistribution of Graduate Medical Education Positions in 2005 Failed to Boost Primary Care or Rural Training” by Candice Chen, Imam Xierali, Katie Piwnica-Worms, and Robert Phillips, in *Health Affairs*, January, 2013:

“Graduate medical education (GME), the system to train graduates of medical schools in their chosen specialties, costs the government nearly \$13 billion annually, yet there is little accountability in the system for addressing critical physician shortages in specific specialties and geographic areas.”

“Medicare provides the bulk of GME funds, and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 redistributed nearly 3,000 residency positions among the nation’s hospitals, largely in an effort to train more residents in primary care and in rural areas.”

“However, when we analyzed the outcomes of this recent effort, we found that out of 304 hospitals receiving additional positions, only 12 were rural, and they received fewer than 3 percent of all positions redistributed. Although primary care training had net positive growth after redistribution, the relative growth of non-primary care training was twice as large and diverted would-be primary care physicians to subspecialty training.”

“Thus, the two legislative and regulatory priorities for the redistribution were not met. Future legislation should reevaluate the formulas that determine GME payments and potentially delink them from the hospital prospective payment system. Furthermore, better health care workforce data and analysis are needed to link GME payments to health care workforce needs.”

Policy Implications—“Analysis of the Medicare Modernization Act’s GME redistribution suggests that small changes made within the bounds of the larger, established GME system cannot sufficiently shift the system to address the nation’s health care workforce needs. **Even though Congress and the Centers for Medicare and Medicaid Services made rural training the number one priority for redistribution, just 3 percent of the positions redistributed went to rural training.** It is unclear why this was the case, but it reflects a fundamental failure of this first effort to purposefully redirect federal funding to producing physicians in areas where access to care is desperately needed.”

“Stronger policy options are needed to address specialty and geographic physician workforce

shortages. This perspective is consistent with recommendations made by many federal advisory commissions, councils, and institutions.”

“To fully address the health care workforce needs of the nation, reassessment of the current Medicare GME payment system is needed. Options include introducing accountability requirements into the current system with sufficient penalties and incentives to truly influence the system and ongoing evaluation to ensure



desired outcomes are met. These accountability requirements could link significantly different levels of payments to evidence of addressing priority physician workforce needs, such as the production of physicians in high-need specialties or physicians who practice in underserved areas. Ongoing program reporting would be required to maintain or adjust any level of payment. This approach would require some expansion of the role of the Centers for Medicare and Medicaid Services to administer the GME payment system.”

“An overhaul of the current system is needed, reevaluating the formula system and potentially delinking payments from the hospital prospective payment system. For both approaches, better health care workforce data, analysis, and planning are needed to guide this system and link the GME system to local, regional, and national health care workforce needs.”

Conclusion—“Graduate medical education is critical in the development of the physician workforce, and it represents the largest public investment in health care workforce development in the United States. Yet the health care system continues to face critical physician shortages in select specialties and geographic locations. The GME system is under scrutiny and faces potential reform, both to reduce costs and to increase accountability for meeting the health care needs of the nation.”

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 in partnerships to make their communities healthier... generates additional revenue by services to non-Members... ongoing use of strategic alliances in pursuit of its Vision. Tim Size, Editor, 880 Independence Lane, Sauk City, WI 53583

www.RWHC.com



Email office@rwhc.com with *subscribe* on the subject line for a free e-subscription.

**21st Annual \$2,500 Monato Essay
April 15 Deadline**

Best Rural Health Paper by a University of Wisconsin student. Submit by April 15th.
Info available at www.RWHC.com

“An analysis of the outcomes of the 2005 redistribution of training positions produced by the Medicare Modernization Act suggests that redistributions and prioritization language within

prevailing GME policy are insufficient to produce significant course corrections. Our findings suggest that clear guidance and accountability are needed to ensure that any future GME redistributions meet intent and, more important, meet need.”

“Our findings also suggest that future GME reforms must include evaluations of outcomes to create accountability for the results of public investments. More broadly, our findings suggest that an earnest public discussion about what the public should expect for this considerable investment is needed to inform a larger reform of GME funding.”

Medicaid Aid: Requesting Reconsideration

From the editorial “Walker’s Medicaid plan falls short for the poor: Higher costs to the state, perhaps fewer insured, and uncompensated care for hospitals make it a poor choice” in the *Journal Sentinel*, 2/16/13:

“*Scott Walker—against Obamacare before he was for it.* We’re not sure whether that will be the governor’s next campaign slogan—or someone else’s.”

“The governor believes he has found a politically palatable solution that allows him to turn down billions of dollars in federal assistance for Medicaid coverage through the Affordable Care Act, yet still claim to increase coverage for the state’s poor.”

“Walker’s proposal is innovative—perhaps even brilliant politically. But is it good policy? We don’t think so. The full Medicaid expansion under Obamacare remains the better choice, and we urge lawmakers to protect the poor by either accepting that or making changes to the administration’s proposal.”

“Walker’s plan to shuffle thousands of needy people between insurance plans will cost the state more and

result in fewer insured than if he had simply accepted federal money available for Medicaid expansion under the ACA. Out-of-pocket costs for those forced from Medicaid may force them to do without coverage, and that could place a greater burden on the state's hospitals."

"The governor's plan would force about 87,000 adults now in the Medicaid program onto the new federal insurance exchanges. That will make way for about 82,000 additional people to receive Medicaid who do not now qualify. Walker claims his plan will allow 224,600 more people to receive coverage, compared with 252,700 if the state had accepted full expansion, though his administration has not explained how it arrived at those numbers. The Legislature and federal officials must OK the plan."

"Under the ACA, the federal government will pay 100% of additional Medicaid costs for three years and 90% there-after. In that scenario, Wisconsin could tap \$4.38 billion in federal money through 2020, according to a preliminary estimate by the state's nonpartisan Legislative Fiscal Bureau. In other words, the state would be money ahead if it adopts full expansion under Obamacare."

"But Walker, long an opponent of Obamacare, is among a group of Republican governors who have chosen to reject the additional federal aid. The concern of Republican governors is understandable: Medicaid is a huge line item in their budgets. President Barack Obama has claimed the ACA won't explode the federal deficit, but that's only true if states pick up a share of the costs of the program over time. With a budget-cutting drumbeat in Washington, D.C., it's reasonable to worry that the federal government won't always pay

90% of Medicaid costs and might push more of the burden onto states."

"But we take the view of Bob Laszewski, an insurance industry analyst and longtime critic of Obamacare. He noted last week that the same argument can be made to oppose any federal matching program. 'Then don't take highway money. Don't take education money,' he told the *Journal Sentinel*."

"Walker and Dennis G. Smith, the state secretary of health services, tout the low premium cost for those forced into the federal exchanges—\$19 a month for a single person whose income puts her at the federal poverty line. But that doesn't include out-of-pocket costs allowable under Obamacare. Those costs are capped at about \$2,000 a year for people with very low incomes, but that's a huge percentage of annual income when you are making less than \$12,000."

"Reacting to Walker's plan, the Wisconsin Hospital Association, which favored full expansion of Medicaid, expressed this concern in a statement: 'There will be much debate on this issue with valid opinions on both sides, but at the end of the day, in this time of uncertainty, we cannot have fewer people with coverage and more uncompensated care.' And yet that's exactly what will happen if the poor either cannot navigate the exchanges or cannot afford the policies they find there."

"As Laszewski and others have noted, the exchanges were not designed for people who were eligible for Medicaid. 'They're designed for middle-class people who can afford deductibles and co-pays,' he said."

"We're also concerned about the quality of coverage. Will the same com-

**Viterbo University Announces
BSN COMPLETION PROGRAM
Three new locations for Fall 2013:
PRAIRIE DU CHIEN, TOMAH & SUPERIOR**

Viterbo University's very popular BSN Completion Program is offering classes in rural Wisconsin locations. Viterbo's program offers:

- Degree completion in approximately two years
- Classes meet one day a week
- New off campus locations in Prairie du Chien, Tomah and Superior as well as our established sites in La Crosse, Madison, Janesville, Chippewa Falls, and Wausau.
- Now recruiting for fall 2013 in the new locations
- Liberal credit transfer
- Portfolio process that allows credit for professional development
- Financial aid for students enrolled in six credits or more each semester
- Our strong reputation for having one of the best nursing education programs in the Midwest

Learn more about Viterbo University's BSN Completion Program at www.viterbo.edu/bsnc/

prehensive benefits offered under Medicaid be available on the lowest tier health plans on the exchanges?”

“Walker’s plan is certainly better than an outright rejection of Medicaid expansion without providing any thing else for the poor. But we’re skeptical that it will accomplish what he claims.”

“While we, too, have concerns about Obamacare—particularly its cost—the state would be better off to accept the federal help and enact a full expansion of Medicaid. We urge the Legislature or the federal government to set this right.”

Boondoggle Undermines Medicare Credibility

From Steve Brenton’s President’s Column, “Bay State Boondoggle” in the Wisconsin Hospital Association’s *Valued Voice*, 1/25/13:

“A recent edition of The Boston Globe included a story about a Massachusetts manipulation of the Medicare wage index rural floor that unless remedied will lead to billions in additional payments to Bay State hospitals, paid for by the rest of the country.”

“This year, Massachusetts will gain more than \$256 million from the wage index increase at the expense of hospitals throughout the country. Wisconsin’s loss will be about \$10 million. Frankly, it’s unfair. And, it is very bad policy.”

“We’re not alone in thinking this way. According to Don Berwick, a well-known health care visionary and former CMS administrator, ‘The entire way the payment system is now calculated has become so complex and so susceptible to gaming and manipulation that you’d play the game yourself if you were running a hospital, to make sure your reimbursements continue to go up. It’s a zero sum game. What Massachusetts gets comes from everybody else.’ ”

“Twenty-one hospital associations and the National Rural Health Association sent a letter to President Obama urging him to include a provision in his 2014 budget submission reversing the rural floor payment

transfer. The coalition—known as The Alliance of America’s Hospitals—is raising awareness of the issue throughout the country.”

“Now, more than ever, reimbursement issues matter. Wisconsin’s hospitals are fighting Medicare cuts on multiple fronts. And, that’s hard enough when the pain is being shared equally. However, it is unfair to expect Wisconsin hospitals to bear these cuts while others play by their own set of rules.”

“Allowing manipulation of the wage index to stand sends a strong message that gaming the system is acceptable. Worse yet, it is a tacit agreement that politics will be allowed to influence health care reimbursement, without regard to consequences or equity.”

RAOnline.org Closes the Info Gap for Rural

From the press release “Rural Assistance Center Celebrates 10 Years of Service to Rural America,” 12/12:

“Grand Forks, ND—Dec. 12, 2012—The Rural Assistance Center (RAC), a national information resource for rural health and human services, is celebrating 10 years of service to rural America. Since its launch in December 2002, RAC’s website, www.raonline.org, has received over 6 million visits, and RAC staff members have responded to over 8,700 information requests from people across the country.”

“ ‘People in rural organizations have to wear many hats. With their multiple responsibilities, time is always at a premium,’ said RAC Program Director Kristine Sande. ‘Because of that, opportunities might be lost, not only for the providers but also the communities they serve. So our mission has always been to level the playing field for rural providers across the country in finding and competing for funding opportunities, staying abreast of current regulations and events, and accessing current information.’ ”

“Based at the University of North Dakota Center for Rural Health, RAC is a collaboration of the University of North Dakota and the Rural Policy Research Institute (RUPRI). It is funded through the federal Of-

fice of Rural Health Policy, part of the Health Resources and Services Administration (HRSA).”

“ ‘In 10 years, the Rural Assistance Center has become a national resource for anyone who wants to know more about rural health or human services,’ said Tom Morris, HRSA associate administrator for rural health. ‘We had high hopes when we initially awarded this grant, and UND and the RAC have far exceeded our high expectations.’ ”

“Chuck Fluharty, RUPRI president and CEO, said ‘The Rural Assistance Center has made a major contribution to the rural health and human services field over the past decade, and the Rural Policy Research Institute is honored to have been a co-founder and collaborator in this journey. Institutional innovation is always challenging, and few organizations can honestly say they have altered the knowledge dissemination dynamics within a field. RAC has done this.’ ”

Vaccine Cocooning to Protect Newborns

By Kristen Audet, Wisconsin Population Health Fellow and RWHC staff for the Southern Wisconsin Immunization Consortium (SWIC).

As a coalition, SWIC works to raise immunization rates across southern Wisconsin. Groups like ours are integral across the nation to increase public education, promote policy changes, and implement other population level interventions to increase public health. However, individual level changes are also important and cannot be overlooked. You can take steps in your own life to promote public health and decrease vaccine-preventable diseases. Your individual changes can help contribute to the overall goal of reducing morbidity and mortality among our youth population.

“Cocooning” is a public health initiative that aims to vaccinate individuals that will be around newborn infants. Mothers, fathers, siblings, grandparents, aunts and uncles and other individuals that will be spending time around a young infant should be vaccinated with Tdap or receive a Tdap booster shot. Cocooning reduc-

es the risk of transmission to the unvaccinated infant until they are old enough to be vaccinated.

The National Foundation for Infectious Diseases publishes real stories from families who have been affected by infectious, vaccine-preventable diseases. Here is a story about a family who wanted to share their story of their child’s experience with pertussis and encourage other families to practice cocooning:

“My now 10 month old son, Peyton, is a pertussis survivor. At only 6 weeks old he developed the disease also known as “whooping cough.” This disease caused my son to have severe coughing attacks, followed by the struggle to catch his breath which caused him to turn purple due to low oxygen levels.”

“During each attack, I listened to my son make these awful high-pitched noises, a sound that is very common in pertussis. As a new mother, the first sounds I expected to hear from my son were small coos and giggles, not the sound of him gasping for air. I worried with every cough, will he catch his breath? The only thing I could do was coach him through it, with a calm tone ‘please breathe Peyton, please breathe.’ ”

“We are not sure how Peyton got the whooping cough, but it might have been prevented had our family known that adults as well as adolescents need booster shots. Just one simple shot could possibly have prevented Peyton and our family from this horrible experience. After three trips to the emergency room, Peyton was tested for pertussis. After five days, the test came back positive.”

“It took time, but finally, he’s back to being a normal healthy child. Not in my wildest dreams did I think that my new healthy son would have to battle with such a terrible disease, at only six weeks old. To all new parents, grandparents, aunts or uncles: please from the bottom of my heart, get your booster shots. It is that important. And since there is too little awareness, please help spread the word about pertussis. It could save a baby’s life.”

Cocooning is one step you can take to protect both yourselves and loved ones. For more info about preventing pertussis go to <http://ow.ly/hSDXI>

Medicine in Search of Meaning

Bill Bazan is a widely respected and long time friend of RWHC, first at the Wisconsin Catholic Health Association and then after he joined the Wisconsin Hospital Association in 1997 as Vice President for Metro Milwaukee, a position from which he retired in 2011. But retirement has not meant slacking off; he is more active then ever with his “Medicine in Search of Meaning” (MISM) Program:

As described by Bill: “A key desired outcome of the ‘Medicine in Search of Meaning’ program is for the participating physicians to reconnect more consciously and deeply with the dreams and positive energy that provided impetus to the pursuit of a vocation in medicine in the first place.”

“The core MISM experience is a seven-hour retreat, usually conducted on a Friday evening and Saturday half-day in an out-of-hospital setting, is based on a small-group discussion format. The retreat helps physicians learn to use new skills to find balance in their lives and to reveal meaning and purpose in their work. Participants identify factors that affect their estimation of personal value and make important connections with fellow physicians through the sharing of common experiences and concerns. The retreat helps physicians reintroduce spirit and joy into the practice of medicine.”

Details on the MISM Program and his blog are at: <http://medicineinsearchofmeaning.blogspot.com>. You can contact Bill directly at bbazan@wi.rr.com. Below are some pretty exceptional endorsements:

“Medicine in Search of Meaning has been and continues to be a moment for physicians to place a pause on their incredibly busy professional lives to ask the all-important question, ‘Am I caring for myself?’ Bill’s ability to take the spiritual wisdom from multiple per-

spectives and traditions provides our physicians with the insight that they must take care of themselves in order to care for their patients.” *Mark Repenshek, PhD, Director, Ethics Ascension Health Care & Healthcare Ethicist, Columbia-St. Mary’s Milwaukee, Wisconsin*

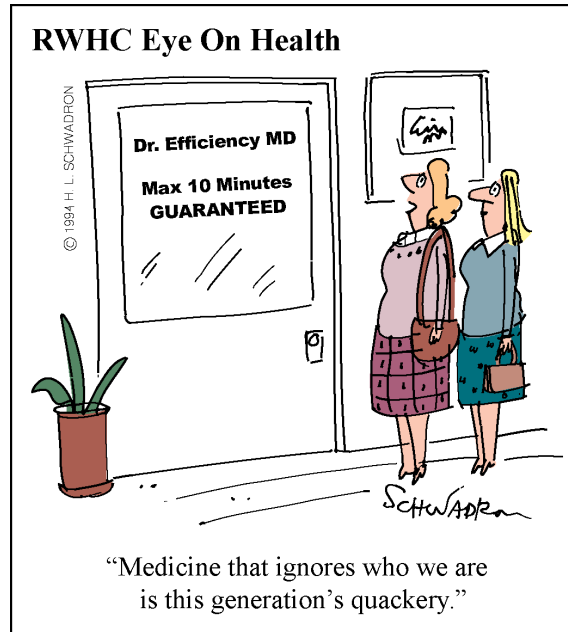
“Columbia-St. Mary’s was a pioneering site for Bill’s Medicine in Search of Meaning program. I was thrilled to sponsor this program on 6 occasions over the past 3 years. With every group you can see that we have created a safe place for building rela-

tionships between physicians that otherwise would not be happening at that level—setting a different context for physicians to engage with each other as human beings not just as professional colleagues.” *Paul Westrick, Vice-President Mission Integration and Advocacy, Columbia-St. Mary’s Health System Milwaukee, Wisconsin*

“Medicine in Search of Meaning is a wonderful, self-reflective book and program experience that will assist physicians to rekindle their passion for medicine and the patients they serve during

these times of tumultuous change in the delivery of health care. Bill has brought the business of the heart and soul back into the business of medicine!” *Marvin Kolb, MD, Minneapolis, Minnesota*

“Having participated in the first Medicine in Search of Meaning program, I realized that Bill Bazan had something substantial to offer to medical practitioners. As one who encouraged him to write, I believe both his book and program will help busy physicians hold their lives still for a time, and will provide an impetus to change, beginning with paying closer attention to the



Support NRHA Rural Leadership Development

The National Rural Health Association has launched a permanent endowment **for programs that identify emerging leaders from and for rural communities**. The mission is to provide training and resources to help them play a lead role in ensuring access to quality health care for rural Americans.

Go to <http://ow.ly/ejmLf> to learn more.

promptings of their inner spirit.” *Glenn Ragalie, MD, Medical Director, Aurora Health Care Hospice, Wauwatosa, Wisconsin*

hire or project team bringing in a member who offers a unique point of view or set of skills that you or the rest of the group might not have. Ask to be challenged: ‘Tell me 2 things about my idea that you think won’t work.’

Leadership Insights: Lessons from First Team

The following is from the January issue of RWHC’s *Leadership Insights* newsletter, “Lessons From My First Team” by Jo Anne Preston. Back issues are available at:

www.RWHC.com/News/RWHCLeadershipNewsletter.aspx

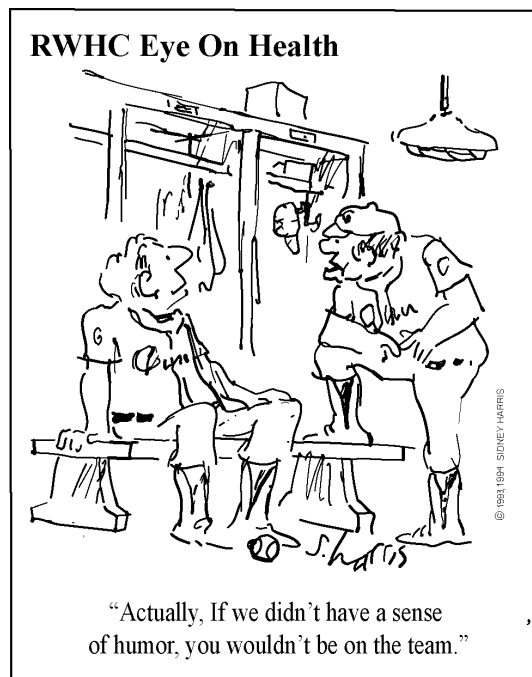
“I grew up on a baseball team, so to speak... my parents had 9 kids, so you could say we all had a position on the team. Now, in the midst of facing the daunting challenges of my father’s final days, I am struck daily that we really are a **winning team**. At every turn, I see this diverse but focused ‘team’ that my parents created show up at the plate when it really counts.”

“Many leaders ask for tips on how to get people to work together better. While a work team is not a ‘family,’ siblings (or cousins, or childhood friends if you don’t have pesky brothers and sisters) are our first training ground for how to play well with others. And managers are not parents either, but in a sense both managers and parents are coaches. Creating a winning team is the goal, and following are some ideas for both to keep in mind:

- **Don’t expect team members to think or act all alike.** Teams that have diversity are stronger because varied viewpoints bring out ideas not considered by others. Even if it is uncomfortable (think family dinners during election season...), most teams benefit by having members who add different perspectives. *Do you tend to surround yourself with like-minded people? Consider in your next*

- **Team members won’t always agree with the boss.** (Oh, how I fought with my dad while growing up!) Disagreeing pushes people to clarify why they are choosing or deciding a certain way. *Don’t label someone as a bad team player just because they disagree with you. Ask: ‘I’d like to understand your way of thinking; can you tell me how you arrived at that conclusion?’ They are more likely to listen to you if you listen to them first, and maybe both of you will learn something you didn’t know before.*

- **Pinky-swear on the big stuff.** ‘We agree, no matter what, we will always ____.’ Make the big things explicit to make sure that even if decisions are hard, there are a core set of principles to which the team is committed. In my family team, repeated key messages instilled by my parents resulted in siblings who trust each other and value love over money. We are far from agreement on some other things, but it is ok because the essentials are in place. A hospital department I coached had several employees who had faced personal illness or loss. The manager had very successfully forged the vision that ‘when someone is in need, we pick up the slack.’ And they did. *What are the ‘essential’ messages you want your team to have as their guideposts? Ask your team, ‘What are the values, goals or unspoken beliefs we all share in common?’*



- **It will be imperfect.** Any relationship worth having will be wonderfully imperfect because we are human. *Expect* conflicts to arise. Most conflict resolution conversations go imperfectly, but when you facilitate a safe environment, stay out of the middle of others’ messes and model holding the difficult con-

versations; it invites others to do so as well. *Help frustrated team members to overlook the small stuff by asking them to reach out toward that person instead of avoiding them, and to look for and reinforce the positives in that team member. If it is not small stuff and you need to address it, then that is a different story.*



brain science. Laughter increases endorphins, boosts creativity and inspires energy to a group to work on a common effort, not to mention what it does for reducing stress. *As a leader, do you encourage laughter? Can you laugh at yourself? Do you and your team laugh at least once a day at work? Make it happen.*

- **Promote asking for back up.** When I was little I dreamt of being an only child—to have my parents to myself and always get to sit in the front seat! But where I would be without my siblings today is unthinkable. Like our work, it's a relay race—you have to have someone to give the baton to because no one person can do it alone. *Recognize your team for when they support, help or teach each other. Though it may seem counter-intuitive here, avoid taking too much on yourself because it doesn't allow others to pitch in and feel needed.*
- **Have some fun now and then (or more often).** 'Going into parenting (or management) without a sense of humor is like going into accounting when you can't do math.' Humor isn't fluff stuff; it is

- **Be a servant leader.** There is no servant like a parent, that is for sure. It is often the most thankless when it is the most difficult, and going into it for the gratitude is really asking for it—maybe a little like management. The team you coach won't win every challenge, or always thank you for your efforts, but in the end, what matters most is what you leave behind."

Contact Jo Anne Preston for individual or group coaching at jpreston@rwhc.com or 608-644-3261. For Info re the RWHC Leadership Series 2011-2012 go to www.rwhc.com and click on "Services" or contact RWHC Education Coordinator Carrie Ballweg at cballweg@rwhc.com or 608-643-2343."

Space Intentionally Left Blank For Mailing