

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

## Protecting Medicare's Rural Health Investment

by Tim Size, Executive Director, Rural Wisconsin Health Cooperative, Sauk City

My red, white and blue Medicare card just arrived. The colors are nice but it would be fine with me to not yet be old enough. In any event, I am now officially an advocate for a rapidly growing number of aging geezers as well as rural providers and rural communities. This is a comfortable role as Medicare depends on us melding all three of these perspectives.

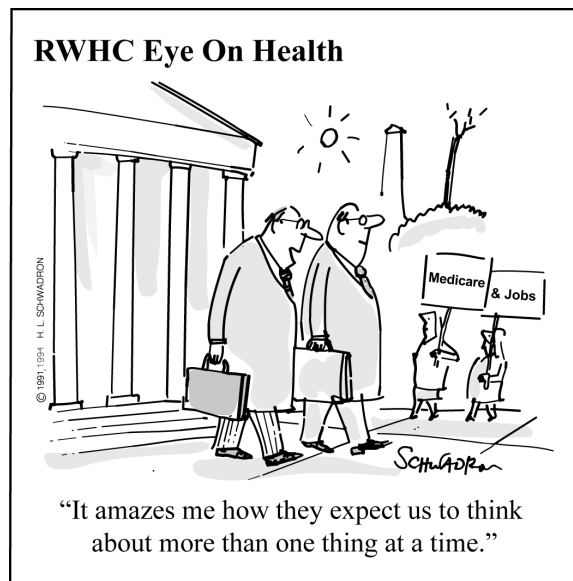
We know that rural health care is vitally important to both the physical and economic health of rural America. We know that business decisions to start, grow or relocate are influenced by the availability of local health care. Rural health care means rural jobs.

But we less often think about the economic impact of rural health care as a major export commodity. I don't mean doctors flying to exotic locations to provide health care. I mean that local health care drives a rural community's economy just like its export of milk, corn, soybeans or manufactured goods.

Rural health care is an export commodity because most of the dollars to pay for it come from banks outside the community. These dollars have left the community in the form of taxes or insurance premi-

ums. These dollars don't return to the community unless the health care is provided locally.

When the dollars do return, they support jobs throughout the community. According to a recent study by the University of Wisconsin Extension and the Wisconsin Hospital Association, for every job created in a hospital, another job is created in the community. Bottom line: jobs in rural America depend not just on how much we spend on health care but where we spend it.



Health care is changing. And I believe for the better. This is true regardless of what happens in Washington over the next year. All of us working in health care know we need to do "more, better for less." At the same time, the rural economy depends on keeping a fair share of health care dollars coming home.

It is a lot easier to keep the jobs in a rural community than to replace them after they are gone. According to the federal Bureau of Labor Statistics, rural counties had 3.7% fewer jobs in December of 2011—four

years after the recession began. In comparison, urban counties had lost 3.3 percent of their jobs. This is no time to squander one of rural America's major job resources—rural health care.

Michael Shuman in his new book *Local Dollars, Local Sense* makes a powerful case for rebuilding local economies. Americans' long-term investments total about \$30 trillion. But not even 1 percent of these savings touch small businesses. He shows investors how to "put their money into building local busi-

nesses and resilient regional economies—and profit in the process.”

Shuman talks about the millions of Americans that want to “put their money to work in the enterprises they know and care about. They want to invest in their own schools, hospitals, factories and homes. For the first time in generations they are thinking about how to invest *locally*.” And that includes Medicare.

Most rural hospitals are non-profits. As such, the largest “investor” in rural health care is Medicare. As Congress struggles to balance the budget and promote the national economy, it is important that it not pull the rug out from under the rural economy through deep cuts to rural hospitals and physicians.

**We must call on Congress to invest our tax money locally and that at a minimum, tax dollars from underserved rural communities return to those communities.** We have a right to health care and jobs beyond urban and suburban America. As previously discussed in this column, most rural hospitals are financially just holding their heads above water. Underpayment by government programs has left them vulnerable. A sluggish economy and an increasingly competitive health care marketplace are taking their toll. Additional cuts are likely to tip many rural hospitals into the red and eventual closure.

*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.

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

Congress must consider the impact of cuts on access to care on the ability of rural providers to serve their rural communities as well as the jobs created in those rural communities. Health care must become more efficient. But we must create greater efficiency while maintaining local access to care and the jobs that come with it.

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## Local Dollars, Local Sense

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A review by Tim Size of “Local Dollars, Local Sense: How to Shift Your Money from Wall Street to Main Street and Achieve Real Prosperity—A Resilient Communities Guide” by Michael Shuman:

Michael Shuman in his new book *Local Dollars, Local Sense* makes a powerful case that the “era of individuals, families and communities depending exclusively on the Rube Goldberg machine we call Wall Street is over.”

This book is for the millions of Americans who want to “put their money to work in the enterprises they know and care about, who want to invest in their own schools, hospitals, factories and homes. For the first time in generations they are thinking about how to invest *locally*.” He shows investors how to “put their money into building local businesses and resilient regional economies—and profit in the process.”

Having been the director of a rural health cooperative for the last thirty plus years, I was particularly interested in the chapter on “The Hidden Power of Cooperatives.” I have long believed in the power of cooperatives and *Local Dollars, Local Sense* is a book for and about local investors and investments. How can a cooperative become an investment vehicle? Shuman explains how cooperatives use patronage dividends to turn profits back to their consumer owners and how many cooperatives (including RWHC) have traditionally solicited loans from their members, at rates that constitute a win-win for both parties.

He goes on to describe a new generation of cooperatives that are on the cutting edge of establishing revolving loan funds and using the cooperative model

to pool individual investments in other community businesses.

“The investment tools outlined here—memberships, member loans, and private equity investment—allow Americans in almost every community to participate in this growing universe of local investments possibilities offered by co-ops.”

This book is a must read for those investors put off by Wall Street and turned on by their local community.

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## Medical Students Embracing Family Practice

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From “Front-line Doctors, More medical students are embracing family practice. *The pay is relatively low, the hours are long, the need is great and the rewards can be immense*” by Anna Gorman in the *Los Angeles Times*, 2/19:

“First-year medical student Hannah Segal sees the same patients and finds herself managing the same ailments during her frequent visits to a community health clinic on downtown Los Angeles” skid row.”

It’s not the most glamorous or desired duty among her classmates, many of whom aspire to prestigious, high-paying medical specialties. But her work on the front lines of patient care has helped Segal find her passion. ‘I’m always really excited to come here,’ she said. ‘I get to really problem-solve over time.’ ”

“The program that brought Segal to this clinic is part of a new nationwide push to address a chronic problem: the U.S. is failing to produce enough family doctors to meet current and future needs.”

“To address the shortage, new medical schools are opening with an emphasis on primary care and others

are changing their curricula to boost the number of graduates interested in the field. Medical school professors are pairing students with family doctors and assigning them to community clinics so they see firsthand what it’s like to practice preventive care and manage chronic diseases.”

“The vast majority of U.S. medical school students have long pursued careers as neurologists, cardiologists or other specialists, resulting in an acute shortage of primary-care physicians that will only get worse as more family doctors retire.”

“The search for solutions is taking on new urgency because healthcare reform will provide an estimated 30 million more Americans with health coverage in two years. And fielding more family physicians is key to the savings promised by backers of the healthcare overhaul.”

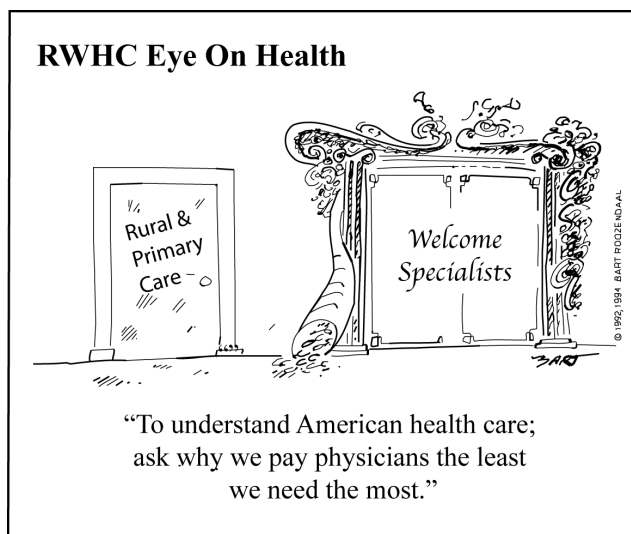
“Without the preventive care and disease management provided by general practice doctors and internists, patients often require more extensive, costlier treatment by specialists and emergency room physicians.”

“ ‘It is an extremely critical problem,’ said Russell Robertson, chairman of the Council of Graduate Medical Education, which advises the government on physician workforce issues. ‘It is certainly contributing to the high cost of

healthcare.... It is a worrisome thing to see how this is going to unfold.’ ”

**“The American Academy of Family Physicians estimates that the nation will be short 39,000 primary-care doctors by 2020.”**

“Experts say changes at medical schools will do only so much, given the long-standing pay gap between primary-care doctors and specialists, which is estimated to reach \$3.5 million over a lifetime. To help, the federal government is joining the effort, allocating more resources to recruitment, training and reimbursement for primary-care providers.”



“Baby boomers’ aging is exacerbating the problem, said Carmen Puliafito, dean of USC’s Keck School of Medicine. ‘Who is going to take care of these people?’ he said. ‘We don’t have good answers to those questions yet, as a nation and as a medical profession.’ ”

“The key to getting more graduates to pursue community medicine is recruiting the right students, said G. Richard Olds, dean of UC Riverside Medical School, which is waiting for accreditation and expects to focus in part on primary care. Olds said that means reaching out to applicants from diverse backgrounds who are committed to serving their communities.”

“Eric Lu, 24, who plans to go into family medicine, said he is drawn to the field because he can become a gatekeeper for patients as they enter the healthcare system and a guide as they move through it. ‘I see the importance of having physicians who are able to really understand patients as people as a whole, not just as individual disease entities,’ Lu said.”

“For many, however, the allure of primary care is outweighed by the downsides. Many family doctors have large patient loads and work long hours in private practices or community clinics. In addition, most healthcare is paid for based on the service provided, and managing chronic diseases and counseling patients on how to live healthier lives isn’t typically lucrative. Family doctors earn from \$175,000 to \$220,000—about half the annual salary of specialists, according to the Assn. of American Medical Colleges.”

#### **2011 Wisconsin Forward Award Goes to Rural Hospital**

“The Wisconsin Forward Awards, the state’s premier organization for the promotion and recognition of high performance management principles, has honored **Grant Regional Health Center** for advancing to the Proficiency Level.”

“Wisconsin Department of Health Services Secretary Dennis Smith presented the awards that recognized Wisconsin Forward Award recipients who submitted applications for review between July and December, 2011.”

“Wisconsin hospitals and health systems are recognized as providing some of the highest quality health care in the country, and the fact that they are continuously striving to improve demonstrates their commitment to excellence,” according to WHA President Steve Brenton.”

*From the March 9<sup>th</sup> issue of “Valued Voice.”*

“With about \$160,000 in educational debt, medical school graduates can’t be blamed for wanting higher-paying jobs, said Atul Grover, chief public policy officer of the academy. ‘If you are looking at uncertainty and a less attractive practice environment and less money, it is hard to convince people to go into primary care,’ Grover said. ‘You can’t hide the realities of how difficult practice lives are.’ ”

“Lu, the Harvard student, isn’t discouraged. ‘I get to do something that I am passionate about,’ he said. ‘It’s worth it.’ ”

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## Rural Physician Residencies: Fact & Fiction

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From “Separating Fact from Fiction” by Train Rural at [www.traindocsrural.org/](http://www.traindocsrural.org/) Their focus is to expose students to Rural Training Track (RTT) residencies.

**The Fiction**—“Outdated equipment. Isolation. No support. Lack of variety in clinical cases. Reduced scope. Poor quality training. Lack of faculty expertise. All reasons to not train rural, right? Not exactly.”

**The Facts**—“Rural training offers some of the most exciting residency opportunities to be had in American medicine. RTTs provide unparalleled continuity of relationships with peers, faculty, patients and the greater community, providing important perspectives in your professional development.”

**“A ‘1-2’ RTT allows a new physician the opportunity to first train in a resource-rich urban center, followed by training in a relationship-rich rural community.** This combination prepares resident physicians for practicing medicine in challenging settings, rural, underserved urban and international, while providing individualized mentoring and coaching during residency. It provides opportunities you won’t see elsewhere.”

**A variety pack**—“Rural practices see a wide variety of cases often surpassing urban ones. In fact, since there are usually fewer specialists around, you’ll end up diagnosing and treating rather than referring. You’ll work on cases your urban colleagues wouldn’t be able to touch. Rare things commonly happen in rural prac-

tice, because there are so many rare things. Even if you do refer cases beyond the capabilities of your rural physician community, you get to see these cases first.”

**Cooperation, not competition**—“You don’t have to compete with other learners for diagnostic and treatment opportunities; there are plenty to go around. Physicians who have gone through rural training have compared it to an apprenticeship, where faculty members treat you like a colleague, and together you learn diagnostic and procedural advances.”

**Get to know me!**—“Not only will you get to know your colleagues better, you also get to know your patients better. Rural communities are smaller, with more of an emphasis on the personal touch. You’ll get to see firsthand how family and community interrelationships can have an impact on health and health care, adding a new perspective to your training and professional development.”

**Flexibility**—“You may end up putting in a longer workweek at times, but the nature of caseloads in rural areas may make being on-call less time-consuming. You may also find that rural training doesn’t put as much bureaucracy in your path.”

**Stretch your talent**—“Rural training lets you expand your skills in ways you may not have expected, whether in dealing with obstetrics, geriatrics or another specialty you would like to try. In rural residency, it’s easier for you to try areas you’re interested in, but may not be easily available in an urban setting.”

**Excellence and Expertise**—“Many rural faculty are at the top of their clinical game out of necessity, having spent their practice lives also working at and expanding the margins of their competence. They’re always learning, always improving, always adding to their clinical repertoire.”

**Living on a budget**—“Rural areas, in general, tend to have a lower cost of living, especially for housing. At the same time, compensation is most often equivalent to what residents in urban areas are receiving, which allows for building up a savings account or getting a head start on loan payments.”

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## Medical College of Wisconsin Enters New Era

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From the press release “Medical College Trustees authorize exploration of statewide community-based medical education program,” 2/12:

“The Medical College of Wisconsin has begun to explore the development of a statewide community-based medical education program to address Wisconsin’s pending physician shortage. The Medical College’s Board of Trustees authorized the College’s administration to conduct feasibility analyses of placing community-based medical school components in one or more regions throughout Wisconsin. The project will be staged over a multi-year period with a goal of launching the first program as early as 2014 and no later than 2015.”

“ ‘Wisconsin needs more doctors. We need to create opportunities for more students from Wisconsin to receive primary care medical education and residency training within our state,’ said Dr. John R. Raymond, President and CEO. ‘The Medical College of Wisconsin is committed to developing an expanded medical education program which addresses this need for primary care physicians in underserved communities across Wisconsin.’ ”

“The Wisconsin Hospital Association’s recent report, ‘100 New Physicians a Year: An Imperative for Wisconsin,’ projected that Wisconsin will need to add 100 new physicians annually to avoid a projected shortfall of 2,000 physicians by 2030.”

“The Medical College envisions an expanded multi-community medical education program centered on an interdisciplinary team approach that would prepare as many as 100 additional medical students per year. The program would focus on preparing students for practice as primary care physicians. It would be structured as an ‘immersive model’ wherein students would live and learn in Wisconsin communities where they eventually might complete their residency training and begin their practice.”



“The community-based medical education program would be created on a partnership model engaging local health care systems, colleges and universities, technical colleges, government and the local business communities. The Medical College also will work closely with the University of Wisconsin School of Medicine and Public Health to coordinate statewide medical education outreach programs.”

“The feasibility study will explore the use of telehealth education techniques and technologies for use at the community-based medical education locations. It also will explore whether science faculty members at local colleges and universities could teach medical school coursework and whether physicians in local health systems could become engaged in clinical teaching.”

“ ‘Two important factors impact the success of the initiative,’ said Dr. Raymond. ‘Local communities must be willing to work in partnership with the Medical College to support this program. Also, there must be the commitment of health care systems statewide to create new primary care residency training positions within their hospitals.’ The feasibility study will determine the capacity for the creation of new primary care residency positions.”

“Since July, Dr. Raymond and Medical College leaders have met with local government officials and leaders of 13 health care systems statewide to discuss the project. As the project progresses, the Medical College’s leadership expects to meet with leaders of health care systems, colleges and universities, technical colleges, and local government officials in the regions under consideration.”

“The Medical College also will study the feasibility of conducting interdisciplinary education at the community-based sites in which courses offered to Medical College medical students would also include students in other health professions programs from other colleges and universities.”

#### 20<sup>th</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)

“The Medical College has received a five-year, \$950,000 grant from the U.S. Department of Health and Human Service’s Health Resources and Services Administration to address the primary care workforce shortage by increasing the number of medical students choosing a career in Family Medicine through the development of a novel curriculum.”

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## Reform’s Access Standards a Rural Priority

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The following is from “Affordable Insurance Exchanges: A Summary of Characteristics and Rural Implications” by the RUPRI Center for Rural Health Policy Analysis at the University of Iowa College of Public Health at [www.public-health.uiowa.edu/rupri](http://www.public-health.uiowa.edu/rupri):

**Extent of influence states exercise over the insurance market:** “Exchanges will certify Qualified Health Plans (QHPs) that can be offered to individuals and small groups purchasing insurance through Exchanges (including the Small Business Health Options Program). States could require QHPs to meet multiple, specific conditions, or to meet only the minimum conditions set in federal regulations.”

*Rural Implications:* “The conditions for QHPs to participate in Exchanges, including the minimum requirements for availability of contracted providers (networks), financial solvency, quality of care, and customer service, may affect availability and cost of plans in rural places.”

**Governance:** “Exchanges may be governed by a state agency or by a private nonprofit entity. The governing body should include adequate technical expertise and representation of consumer interest.”

*Rural Implications:* “Governing bodies must consider rural implications of decisions such as contracting with navigators and certifying QHPs. Rural representation, both for technical understanding and consumer interests, is essential.”

**Enrollment/Navigators:** “Exchanges will provide grants to organizations to be consumer navigators—to help consumers assess their options and choose among

competing QHPs. Navigators will provide public education, information about tax credits and cost sharing, summaries of QHP options, and guidance on using a consumer assistance program to resolve complaints.”

*Rural Implications:* “Exchanges should review navigator proposals to ensure that proposed strategies can reach all populations. In particular, strategies should address ethnic and cultural differences and ensure access to the venues through which information is made available. Navigators should be required to evaluate their strategies and demonstrate that rural populations are served effectively. If necessary, Exchanges should solicit participation in the navigator program from nonprofit, rural-based organizations.”

**Access Standards:** “Exchanges will implement specific access criteria in certifying QHPs, consistent with the final rule published by the Centers for Medicare and Medicaid Services, yet to be written.”

*Rural Implications:* “Exchanges should ensure that rural residents have choices that include local providers in their networks and/or that allow enrollees to use local, out-of-network providers, with no additional out-of-pocket expense as compared to network providers.”

**Raising Childhood Immunization Rates:  
Working Together to Cut Through the Barriers**

The Southern Wisconsin Immunization Consortium (SWIC) will be host a kickoff meeting April 24th at the Iowa County Health Department in Dodgeville. Come at 5:30 pm for dinner and networking. The meeting will begin at 6:30 pm and Dr. Paul Hunter, from the Department of Family Medicine at the University of Wisconsin School of Medicine and Public Health will be speaking on Personal Conviction Waivers at 7:00 pm.

Register at [SWICOffice@rwhc.com](mailto:SWICOffice@rwhc.com) to learn more about SWIC and what you and your community can do to increase rural immunization rates.

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## Words Are Powerful

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The following is from the 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)

“Most will agree that actions speak louder than words, but this does not mean words don’t influence. Some words we use may unwittingly interfere with our ability to earn respect or be effective as a manager. This is not about being politically correct. The idea is to think intentionally about how we speak and whether or not our words work *for or against* our employees’ needs to feel respected, dignified, important, valuable and successful. Consider the following.”

“**Subordinate**—Managers often use the word *subordinate* to refer to people who report to them. The definition of subordinate is ‘**less important, subservient and inferior.**’ Those are not the words most employees would call motivating or inspiring. What is a better way to refer to the group of people whose best efforts and high engagement will make *you* successful?”

“**LDI, HRSA, HIT, ETC.**—Listen to your speech for acronyms. We use them so often and they can be shortcuts, but the trouble is we assume everyone knows what we are talking about. Employees can feel stupid if they have to ask, and when questions go unasked, we don’t speed up at all. Better to go with the assumption that not everyone knows what your acronym stands for. Speak it like you write it (acronym followed by the spelled out version).”

“**Using the terms ‘Leader’ and ‘Manager’ interchangeably**—I was recently challenged on this one. I tend to call all people in official positions of management ‘leaders’ and have backed away from differentiating the two terms. An employee who was not a manager asked me if I thought non-managers could be leaders in their roles and of course I said yes. He then asked me why I kept referring to leadership as if it were synonymous with manager. He was saying that the words I was using made him feel like he could not be a leader if he was not a manager. Point taken.”



**“I’m a Perfectionist**—Even if you state you are only this demanding on yourself, when you tell employees you are a perfectionist, what they often hear is that you really expect them to be perfect too. We want employees to openly discuss mistakes so that we can all learn from them and be willing to ask questions when they are unsure. Expectations of perfection shut the door on those kinds of conversations. How about striving for excellence instead of perfection?”

**“I/Me**—It’s so easy to slip into using I/me when we are so invested in our work. Just watch for opportunities to say us/we when you can. It’s more inclusive.”

**“The Girls**—A department made up of all women referred to as ‘the girls’ is likely going to be offensive to most grown women. When I have heard this used, I don’t believe the manager *intended* it to be belittling. It just doesn’t come across as empowering, and there are better options.”

**“Blah, blah, blah**—You know it when you hear it. You try to track with the speaker but your mind keeps drifting to what you need to pick up from the grocery store. Intelligent words come out of a speaker’s mouth but all

you hear is blah, blah, blah. (I suspect I’ve been that speaker at times). We use buzzwords, big words, the latest ‘in’ designer phrase created by some ‘wonk’ and we lose people. John Kotter, author of *Leading Change*, talks about this in relation to creating a vision for your change effort. Compare the following two versions of the same vision.”

- a) “Through a process of de-bureaucratization, we will empower our frontline employees to better serve idiosyncratic customer requirements.”
- b) “We are going to throw out some of the rule books and give employees more discretion to do the right thing for our customers.”

“Which one inspires you?”

*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.*

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