

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

### Calm in the Eye of the Storm

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

In 40 years working in and studying health care, I have never seen a more challenging time. I'm not suggesting that you need to hug a healthcare worker, or even your hospital administrator, yet.

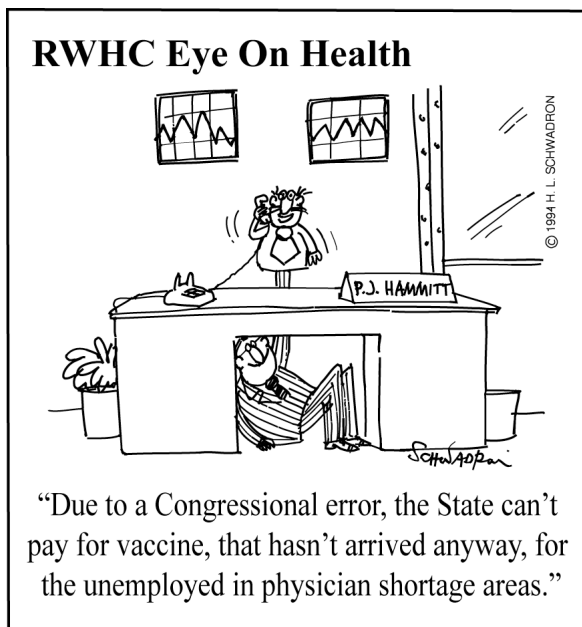
On a typical day, they are working to protect their patients and community from the effect of not one storm but a plague of once in a generation storms. You see or hear about these events every day but you may not know how they pile up on your local hospital or clinic. Think of the uncertainty on the ground around federal healthcare reform, of state budget shortfalls, of physician and healthcare workforce shortages, the effects of the global recession, and of course, H1N1. Each one of the five is a big challenge. All five at one time would cause any of us to do more than lose sleep.

Let me be clear, I am not whining on behalf of friends and colleagues who work in the front lines of health care; just the opposite—I stand in amazement at their calmness.

H1N1 brought sick patients into facilities with unvaccinated staff at a high risk of getting it and passing it

on. Due to distribution problems of limited H1N1 vaccine, one nurse described the feeling like being sent into a war without weapons. Other supplies like needles and facemasks are abundant in some communities and chronically short in others. By chance, some staff got a seasonal flu shot early, while others won't be able to get one this year.

The recession has caused the need for charity care to go through the roof. At the same time, the ability to provide charity care has fallen through the floor. Pay freezes, or even cuts, and layoffs have been necessary. The stress felt has risen.



Unemployment is at all time highs. But even in the recession, there are many shortages of health care professionals in rural communities. And hospitals and clinics are already scrambling as they work to prepare for even bigger shortages. Healthcare workers are mostly baby boomers. These healthcare workers are beginning to retire out of health care and increasingly, with age, into becoming patients themselves.

Hospitals, clinics, nursing homes and other providers are facing deep cuts in state payments that are already inadequate for Medicaid enrollees. In Wisconsin, the rightly praised growth of "BadgerCare" to expand access to insurance has brought the downside of providers being more vulnerable to further Medicaid under payment.

And then there is national health care reform. Part of me wants Congress to get it right, but another part just wants them to tell me the new rules so we can get on with it. In any event, fundamental change to a sixth of our country's economy will require years of additional legislation and regulation. In the meantime, those of us who care about rural health need to be nimble to address the risk of ideas developed in urban communities and not tested in rural ones.

On second thought, just for prevention sake, a hug might not hurt.

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## Regional Cost Variation Not Just Urban issue

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From "The Uneven Cost of Rural Health Care" by Bill Bishop and Julie Ardery in the *Daily Yonder* (<http://www.dailyyonder.com>), 10/21/09:"

"The nation is spending vastly more on health care in some rural areas than in others without any indication that the increased spending results in better health."

"In Whitefish, Montana, the average yearly cost of taking care of a Medicare patient over a three-year pe-

### RWHC BLOGS

**The Rural Health Advocate:** [www.ruraladvocate.org/](http://www.ruraladvocate.org/)  
Speak back to this newsletter! Now you can—selected editorials and cartoons are now inviting your opposing and supporting comments.

**Rural Health IT:** [www.worh.org/hit/](http://www.worh.org/hit/)  
Intended to provide resources, opinions and the opportunity to discuss issues relating to the HIT provisions and requirements of the American Recovery and Reinvestment Act, specifically relevant to rural healthcare.

riod ending in 2006 was \$3,950. Across the country in the Florida Panhandle town of Graceville, the cost of tending a Medicare patient during the same time was nearly \$15,500."

"People in Graceville are poorer than people in

Whitefish, it's true. But the difference in cost of caring for a Medicare patient in these two towns is astounding—more than four times more expensive in one rural Florida hospital than in one town in rural Montana."

"The map below shows the wide range of costs in caring for Medicare patients among 2,990 rural and exurban hospital service areas. The map, the first of its kind, is based on a remarkable set of data collected by researchers at the Dartmouth Medical School. Doctors and economists there take a sample of Medicare costs from every hospital. They account for differences in race, sex and age from place to place, but not income. What they have discovered are large differences in medical costs from one part of America to another."

" 'This map illustrates that variation in health care spending is not just about big city versus rural areas,' Dartmouth College economist Jonathan Skinner told *The Daily Yonder*. Skinner said this 'landmark map' showed that 'even within rural there is a large variation in costs.' "

"Those costs are not explained by differences in population or in health outcomes, according Dartmouth researchers. 'Regional differences in poverty and income explain almost none of the variation,' Skinner and a team of researchers wrote in a recent issue of the *New England Journal of Medicine*."

"Places with sicker patients do spend more, Skinner writes, but that discrepancy accounts for only 18% of the total difference between the highest and lowest cost regions. Skinner calculates that 70% of the difference between high and low-cost areas is due to 'discretionary decisions by physicians.' Doctors in some areas order more tests, hospitalize more patients and consult more specialists than do doctors in other places. (Remember that health outcomes are

**RWHC Eye On Health** is the monthly newsletter of the 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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generally better in low cost areas, according to Dartmouth's research.)”

“The Dartmouth data has become central to the national debate over health care costs and reform. A recent article in *The New Yorker* magazine compared a high cost health care region around McAllen, in the Rio Grande Valley of Texas, with a low cost region in and around the western slope city of Grand Junction, Colorado. The author, Atul Gawande, found that low cost areas had better health outcomes than high cost areas—and his article soon became must reading in the Obama White House, which is looking for ways to lower the overall cost of health care.”

“*The New Yorker* article and all other studies using the Dartmouth data refer to hospital regions. There are just over 300 hospital regions, all containing metropolitan areas. It was impossible to tell if the same wide variation existed among rural hospitals by examining only the large regions.”

“To determine costs in rural America, the *Yonder* used per capita Medicare costs from ‘hospital service areas’ (HSAs). There are nearly 3,000 HSAs, and 1,843 of these contain a majority of people living in rural or exurban zip codes.”

“The map above shows that the same differences in cost described in Gawande’s *New Yorker* article from one city to another also exist within rural America.”

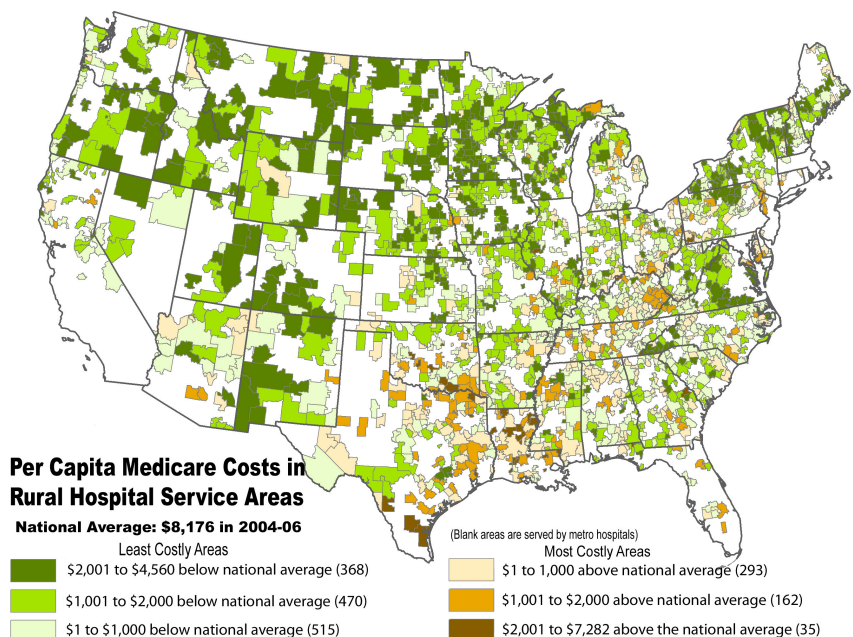
“The green areas on the map denote hospital service areas that spent below the national average of \$8,176 per patient (averaged from 2004 to 2006) for Medicare patients. The brown areas spent above the national average. The white areas represent urban hospital service areas, and in a few cases, areas with no data (For a large portion of western Maine, for instance, there was no data).”

“Rural areas generally spend less than the national average on Medicare than do urban areas. Only 27% of rural hospital service areas had per capita Medicare costs above the national average from 2004-2006.”

“But the differences among rural areas are as great as the cost variations from one metro region to another. Moreover, the high cost rural service areas are generally in the same places where there were cities with high Medicare costs. Gawande wrote about the high charges for Medicare patients around McAllen, a metro area. Medicare costs in the rural regions of far South Texas are among the highest cost in the nation, also. Louisiana has the highest costs statewide; and six of the ten most costly rural hospital service areas are in Louisiana.”

“One reason for the disparity in costs from one rural service area to another could be differences in health, Skinner told the *Yonder*. ‘It’s not surprising that people in worse health use more health care,’ he said. Poverty doesn’t create higher costs, Skinner says. Poor health does.”

“Yet poor health alone doesn’t explain the differences in cost from one rural place to another. In Southeastern Kentucky, for example, there are a number of high cost hospitals, and, historically, the Kentucky mountains have had high rates of illness and disability. The hospital service area in Pineville, however, is low cost, even though it serves a poor population that is very similar to the high cost areas around it. Similarly, West Virginia has mostly low cost rural hospitals while rural hospitals in Mississippi are high cost. Yet both are generally poor states. ‘It’s not simply poverty that explains these differences,’ Skinner said. ‘Poverty doesn’t have a lot of effect on spending; it’s the fact that people are sick’.”



“In Whitefish, Montana, hospital administrator Jason Spring said he noticed that the Obama administration had promoted Grand Junction and the Mayo Clinic in Minnesota as examples of low-cost medicine, ‘and we were lower than all of them.’ ”

“Spring said that Whitefish had a ‘healthy population...a lot of people involved in fitness, skiing or hiking, a community really focused on health.’ He also said his area of northwestern Montana had a ‘really strong primary care base here. (Primary care doctors) are managing those illnesses wisely.’ Dartmouth research has found that high cost regions refer patients more frequently to specialists.”

“Spring also said the size of the community helped. Doctors in Whitefish talk to one another. ‘There’s strong communication between the specialties here because it’s a small enough community,’ Spring said. Gawande found that doctors in low-cost Grand Junction and at Mayo were in constant contact about patients’ care. The North Valley Hospital is the second lowest cost rural hospital in the country, just above the hospital serving Bonners Ferry in the northern tip of Idaho. North Valley sits next to Glacier National Park. Pretty spectacular setting, and low cost care.”

“Spring’s North Valley Hospital is also owned by a local foundation, not by doctors. Skinner said he ‘wouldn’t be surprised if in some high cost areas you had high numbers of physician-owned hospitals.’ ”

“There are statistical reasons some hospital service areas could be showing extremely low or high costs. Veterans who qualify for Medicare but receive their treatment at VA facilities reduce the overall Medicare bill for a service area. If there are a large number of these older vets in an area, it could reduce the overall Medicare bill.”

“Since the Dartmouth data is based on a sample, it’s also possible that an extremely expensive patient could

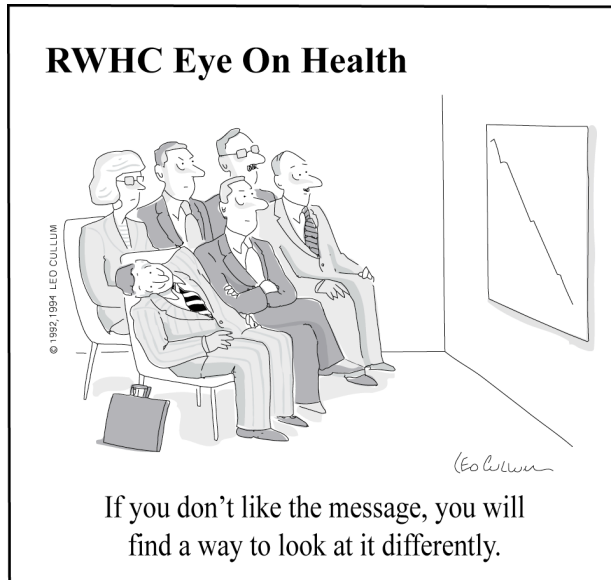
inflate a hospital service area’s average cost. To smooth out these fluctuations, the Yonder averaged three years of data.”

“What the map of rural hospitals shows ultimately, Skinner says, is that there are quite significant cost differences from one hospital to another that can’t be explained by poverty, age, sex or race. The nation is spending vastly more on health care in some areas than in others without any indication that the increased spending results in better health.”

“ ‘Medicare spending in 2006 varied more than threefold across U.S. hospital referral regions,’ Dartmouth researchers reported earlier this year in a publication subtitled *More Isn’t Always Better*. ‘Research has shown

that some of the variation is due to differences in the prices paid for similar services, and some is due to differences in illness; but even after accounting for these factors, twofold differences remain. In other words, the differences in spending are almost entirely explained by differences in the volume of health care services received by similar patients.’ ”

“Those differences are as great or greater in rural America.”



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## Telestroke Coming (Slowly) Into Its Own

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From “Telestroke Programs Link Stroke Specialists to Patients Unable to Access Care” by Cynthia Johnson in *HealthLeaders*, 10/30/09:

“On April 6, Michael Harrigan, 58, was driving 70 mph on Interstate 94 from Milwaukee to a business meeting in Madison, WI. He never did make it to his meeting, because he suffered a stroke halfway there. The series of events that occurred following his stroke are nothing short of miraculous.”



“Harrigan was able to pull over his car and call 9-1-1 despite having palpable stroke symptoms. His face was beginning to slump, he lost control of his left hand, and he was having difficulty speaking.”

“What Harrigan didn’t know at the time was that the hospital he was transported to by ambulance, had just implemented a telestroke program in Madison on a 24/7 basis.”

“A stroke specialist in Madison was able to evaluate Harrigan using remote brain imaging technology and videoconferencing tools. As a result, he was given tissue plasminogen activator (tPA), a clot-busting drug which needs to be administered within the first three hours of an ischemic stroke in order for it to be effective.”

“ ‘I am clearly very, very blessed and lucky that I happened to be able to take advantage of the telestroke program,’ says Harrigan. ‘I’m certain that without it I would have had more permanent damage and probably even more serious complications, including life-threatening ones in my opinion. It really could have been very serious.’ ”

“Instead, Harrigan was transferred to a clinic in Madison, where he spent the next week in their ICU before he was transferred to cardiology. He was eventually diagnosed with an atrial fibrillation.”

“In May, the American Heart Association (AHA) and American Stroke Association (ASA) published groundbreaking statements recommending the use of telemedicine technology on stroke patients. The AHA and ASA cite that the US has a mere 4 neurologists per 100,000 people who need to care for over 780,000 acute strokes per year, many of which occur in parts of the US that do not have access to acute stroke services.”

“The statement encourages the use of telemedicine technology to bridge the gap by providing medical specialists with the data necessary to assist remotely-located bedside clinicians in stroke-related decision making for patients.”



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## Strong Rural Health Means Local Care & Jobs

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From “Rural Health Providers Improve Health Of Economy, Not Just Patients” by Lynda Waddington” in the *Iowa Independent*, 10/27/09:

“The steady decline in rural health care access can take a toll on patients’ health. But it can also impact the economic well-being of rural communities. When health care providers leave a geographic area—either by choice or by retirement—the surrounding community loses a significant portion of its tax base.”

“For the past several months, the *Iowa Independent* has documented the health costs associated with provider shortages in rural areas. Without sufficient providers, some rural residents are forced to travel significant distances for general health, mental health, dentistry and pharmaceutical services.”

“According to a 2007 study by the National Center for Rural Health Works at Oklahoma State University, one full-time primary care physician generates, on average, approximately \$1.5 million in revenue, \$900,000 in payroll and creates 23 jobs. The relatively large impact is created through clinic employment, inpatient services, outpatient activities and the multiplier effect of these contributions, and it does not include potential benefits to local pharmacies.”

“The study also documents another important factor: If primary health care services are not available in a rural town, residents will often travel to the nearest urban centers to meet their needs. Because such urban centers often provide expanded shopping and specialty service opportunities, the traveling patients will often make other purchases out of town that may have otherwise made locally.”

“In many ways, a general practitioner’s economic contributions are as important to a community as his/her medical contributions.”

“The National Center for Rural Health Works estimates that a rural community with a shortage as low as one-half of one full-time physician stands to lose \$236,565 from clinic visits and \$451,169 net revenue at a local hospital for inpatient and outpatient activity.

When those figures are adjusted for indirect multipliers—for example, services purchased by the physician, the clinic and employees—the total impact of the shortage was 13.8 jobs and \$533,493 in income.”

“Despite all the evidence, few rural areas currently target medical professionals as a part of their routine economic development efforts.”

“ ‘Some of our larger communities struggle to attract health care providers to those communities, and I know that it gets very competitive as far as what they need to do in order to draw physicians, physician assistants, nurse practitioners, primary care providers and the whole gamut of health care providers,’ said Tom Newton, director of the Iowa Department of Public Health.”

“Somehow we need to reinvigorate those communities and show the benefits that they have and what they can offer to providers who are willing to go out there and work.”

“It is typically only when a primary care physician leaves a community or retires that residents and local leaders understand the impact of that business on the local economy. And, unfortunately, creating a medical practice from scratch instead of transitioning from one physician to another is a much more formidable task.”

“There are, however, promising approaches rural communities could take to reduce the decline of medical professionals, but none is in widespread use.”

“Some rural communities are taking a ‘grow your own’ approach, whereby community groups attempt to identify young adults—even as young as middle school or junior high students—who might have an interest in attending medical school. Through scholarships and other incentives, they pay for a student’s medical training in exchange for a promise to return to the community and practice medicine there.”

“Although most rural communities have been slow to adopt this approach, it is gaining momentum as smaller communities are faced with aging medical providers and few prospects to fill those potential voids in service. According to Newton, such approaches to provider shortages have been ‘the most effective’ in bringing providers into rural areas.”

“ ‘It is much easier for a young person to go back into a rural community if that’s where they grew up, and if that is where they raised, because they understand the benefits of living in those rural communities’ he said.”

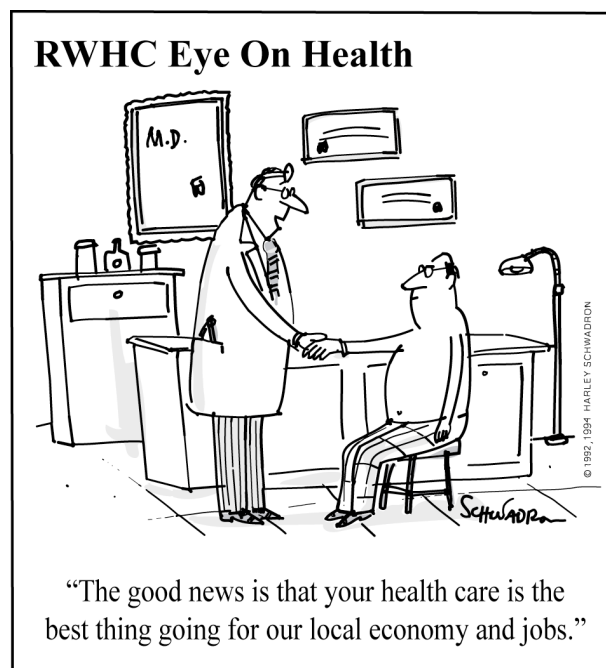
“Another, somewhat more popular method of training physicians and other health care providers for service in smaller communities is the implementation of rural

residency programs. Not only do programs such as the Smoky Hill Family Medicine Residency Program in Kansas and the Durant Family Medicine Residency Program in Oklahoma prepare physicians for work in smaller communities and rural areas, but they also provide a boost to local communities where they operate.”

“ ‘I think we also need to do a better job of selling what we have in Iowa. We don’t do that. We make a lot out of the fact that we don’t have oceans and we don’t have

mountains, and everyone is under the assumption that is what attracts young people today. Well, to some degree it does. But, eventually those young people get married, have kids and have other priorities that begin to take precedent in their lives,’ Newton said. ‘If they understand that there are safe communities, that have good schools, that have short commutes—ones in which there is a sense of community and they know their neighbors, and their patients and they can have a real relationship with them—there are aspects of that which are very appealing to people.’ ”

“As the recession takes its toll and small town populations continue to age, health care providers will become an increasingly important part of rural economic



development. Doctors are an important component of the rural economy, improving conditions far beyond the walls of an examination room.”

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## Osteopathic Medicine Looks at Whole Person

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The following is from the American Association of Colleges of Osteopathic Medicine:

“Osteopathic medicine is a distinct form of medical practice in the United States. Osteopathic medicine provides all of the benefits of modern medicine including prescription drugs, surgery, and the use of technology to diagnose disease and evaluate injury. It also offers the added benefit of hands-on diagnosis and treatment through a system of therapy known as osteopathic manipulative medicine. Osteopathic medicine emphasizes helping each person achieve a high level of wellness by focusing on health promotion and disease prevention.”

“Osteopathic medicine was founded in the late 1800s in Kirksville, Missouri, by Andrew Taylor Still, MD, who recognized that the medical practices of the day often caused more harm than good. Still focused on developing a system of medical care that would promote the body’s innate ability to heal itself. He called this system of medicine osteopathy, now known as osteopathic medicine.”

“Osteopathic physicians, also known as DOs, work in partnership with their patients. They consider the impact that lifestyle and community have on the health of each individual, and they work to break down barriers to good health. DOs are licensed to practice the full scope of medicine in all 50 states. They practice in all types of environments, including the military, and in all types of specialties, from family medicine to obstetrics, surgery, and aerospace medicine.”

“DOs are trained to look at the whole person from their first days of medical school, which means they see each person as more than just a col-

lection of organ systems and body parts that may become injured or diseased. This holistic approach to patient care means that osteopathic medical students learn how to integrate the patient into the health care process as a partner. They are trained to communicate with people from diverse backgrounds, and they get the opportunity to practice these skills in their classrooms and learning laboratories, frequently with standardized and simulated patients.”

“The osteopathic medical profession has a proud heritage of producing primary care practitioners. In fact, the mission statements of the majority of osteopathic medical schools state plainly that their purpose is the production of primary care physicians. Osteopathic medical tradition preaches that a strong foundation in primary care makes one a better physician, regardless of what specialty they may eventually practice.”

“Today, when the challenge of ensuring an adequate number of primary care physicians extends to osteopathic medicine, the majority of most osteopathic medical school graduates choose careers in primary care. Osteopathic medicine also has a special focus on providing care in rural and urban underserved areas, allowing DOs to have a greater impact on the U.S. population’s health and well-being than their numbers would suggest. While DOs constitute 7 percent of all U.S. physicians, they are responsible for 16 percent of patient visits in communities with populations of fewer than 2,500.”

“Osteopathic medicine is also rapidly growing! Nearly one in five medical students in the United States is attending an osteopathic medical school.”

“In addition to studying all of the typical subjects you would expect student physicians to master, osteopathic medical students take approximately 200 additional hours of training in the art of osteopathic manipulative medicine. This system of hands-on techniques helps alleviate pain, restores motion, supports the body’s natural functions and influences the body’s structure to help it function more efficiently.”

### **National Rural Health Association Annual Policy Institute—January 25-27th**

Health reform may dramatically change the delivery of health care in rural America. Learn how you and your facility may be impacted by new legislation, how you can insure health reform works for rural patients and providers, and how to effectively advocate at the national level on behalf of rural health.

Capital Hilton, 1001 16th Street NW, Washington, DC

Register online at: [www.nrharural.org](http://www.nrharural.org)

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## Health Reform & Expanded Rural Coverage

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From: “Expanding Health Insurance Coverage for Rural Residents through Health Reform” by Coburn A, MacKinney AC, McBride T, Mueller K, Slifkin R, Rural Policy Research Institute and Robert Wood Johnson Foundation, 10/29/09:

*The completed 12 page report can be downloaded at <http://www.rwjf.org/files/research/50808.pdf>*

“Rural residents of the United States have a higher uninsured rate than their urban counterparts, and therefore have the most to gain from efforts to reform the U.S. health care system.”

“Released by the Rural Policy Research Institute and funded by the Robert Wood Johnson Foundation, the *Assuring Health Coverage for Rural People through Health Reform* brief suggests that the challenges that

rural people face in obtaining health insurance are partly due to the structure of the rural economy: 64 percent of adults working in rural are employed in jobs where health insurance is provided, compared to 71 percent of their urban counterparts. At the same time, rural workers are far more likely to be self-employed. Rural businesses also pay higher premium costs than urban businesses for similar health insurance plans.”

“Researchers found that health reform proposals that include (i) a subsidy for individual purchase, (ii) availability of insurance plans to individuals and small groups through exchanges, and (iii) expansion of Medicaid would significantly improve coverage for rural populations. In fact, the total number of un-

insured people in rural areas would decrease to 1.9 million from the current 8.1 million—leaving only 4.2 percent of rural Americans without insurance, less than the 5.9 percent projected in urban areas.”

### **18<sup>th</sup> Annual RWHC Monato Essay Prize**

A \$2,000 Prize for the Best Rural Health Paper by a University of Wisconsin student is given annually by RWHC's Hermes Monato, Jr. Memorial Fund. Write on a rural health topic for a regular class and submit a copy by April 15th. Info re submission is available at [www.rwhc.com](http://www.rwhc.com)

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