Rural Wisconsin
Health Cooperative

Eye On Health

Review & Commentary on Health Policy Issues from a Rural Perspective - March 1st, 1999

WI Communities Need State AHEC Support

Rural communities need help as the state budget is debated--support $1.5 M/Yr. for AHEC.

While Wisconsin may on average have an adequate supply of physicians and other practitioners, rural and inner city communities continue to face chronic local shortages--a distribution problem with a variety of causes ranging from lower payments to rural providers to an array of deeply ingrained biases that tend to steer students and graduates away from "less desirable" communities. To help address this problem, the Wisconsin Area Education Center System (AHEC) was developed in 1991, following a legislative intervention aimed at breaking a planning dead-lock between the state's two medical schools.

Eight years later, the Wisconsin Area Education Center System is in its final year of federal core funding. While state support has grown steadily, the primary source of funds, until last year, has been federal, controlled by the Medical College of Wisconsin with administrative assistance from the University of Wisconsin.

The system is now overseen by an incorporated statewide organization of academic and community partners; administration of both federal and state funds is now being handled by the University of Wisconsin. Wisconsin, unlike most if not all other AHEC systems, has shifted control of its community-academic partnerships from "academe" into a cooperative enterprise. It is this new partnership that has asked for $1.5 million for each year of the 1999-2001 biennium. This represents a zero percent increase in program funding but completes the transition off of core federal funding. The current draft budget includes only $800,000 per year.

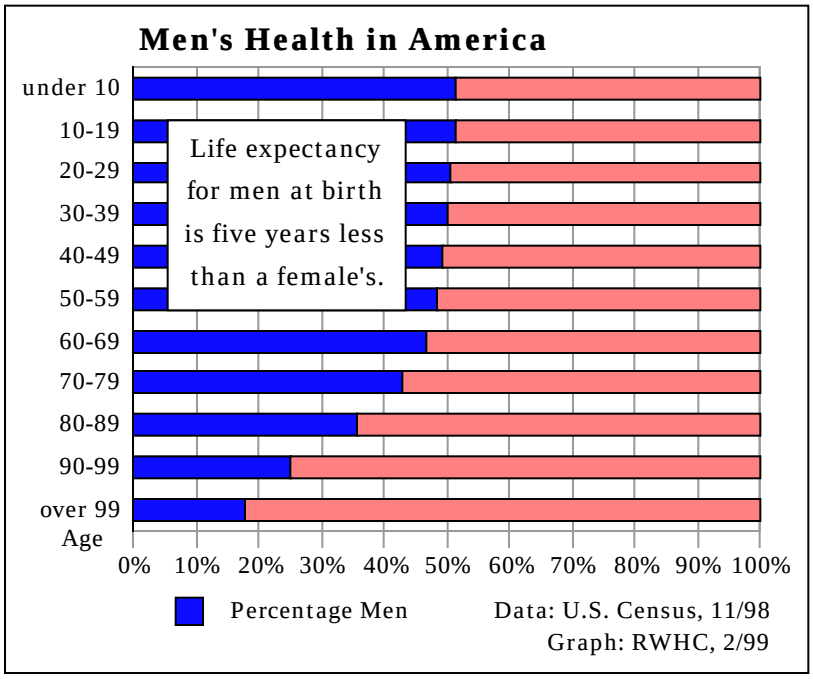
The value of AHEC funding continuing at least level can best be understood by looking at just several of the academic-community bridges it helps to support. The following is taken from the formal AHEC budget request sent to the state Department of Administration:

"**Development of Rural Training Track residency programs.** Rural training for family medicine residents has proved to be the most significant educational strategy for placing doctors in rural communities."

"**Expanded opportunities for medical and other health professions students to train in rural communities.** AHEC works with the various health professions schools in Wisconsin to match the health care needs of communities with health professional student training experiences."

"**Support for extension of dental services to underserved communities through development of community-based training sites for dental students.** AHEC collaboration with Marquette University's School of Dentistry has enabled the school to expand its mission to provide services to rural and urban underserved communities of Wisconsin."

"**Physician Assistant, Nurse Practitioner and Certified Nurse Midwife training and recruitment.**" AHEC supports communities recruiting local professionals to upgrade skills--"growing their own."



"For every complicated problem, there is a simple, and a wrong, solution." H.L. Mencken

Medicare Fails to Consider Rural Impact

From *Taking Medicare into the 21st Century, Realities of a Post BBA World and Implications for Rural Health Care,* by the Rural Policy Research Institute Rural Health Panel with principal authors: Keith J. Mueller, Ph.D. and Timothy McBride, Ph.D., 2/10/99:

"The Balanced Budget Act of 1997 (BBA) initiated changes in the Medicare program that have significant potential to alter the landscape in rural health, changing the way care for rural beneficiaries is financed; and, subsequently, the structure of the rural health delivery system. BBA implementation is an evolving process, beginning with federal regulatory policies and eventually leading to local responses, which will require years to complete and assess."

Impacts on Rural Hospitals

"The BBA affects the major categories of payment to hospitals' inpatient and outpatient services as well as a host of other services offered by hospitals. The impact in any given category may be absorbed as only a small percentage of any hospital's total Medicare payments, but the combined impacts could threaten the viability of providing Medicare services, and perhaps the financial security of the hospital. At this early time in the post-BBA era, we cannot be certain about the ultimate outcome in service availability, but we can develop scenarios to illustrate the potential outcome."

"Changes in Medicare payment can have a disproportionately negative impact on many rural hospitals, as a function of hospital size, dependency on Medicare revenues, share of Medicare business that is through the traditional program, and hospital management. In hospital fiscal year 1995 (actual months vary across hospitals), 15.9 percent of rural hospitals experienced negative total margins, as compared to 9.8 percent of urban hospitals. Among rural hospitals, only 2.5 percent of rural referral centers had negative margins, compared to 18.2 percent of sole community hospitals and 15.8 percent of all other rural hospitals. To be more specific to a provision of the BBA, use of prospective payment to derive savings from hospital outpatient payment, those payments account for 9.5 percent of revenues for rural hospitals, as compared to 7.1 percent for urban hospitals. All types of rural hospitals are between 9 and 10 percent dependent on Medicare outpatient payment for their revenues. Further analysis shows that the smallest hospitals are the most vulnerable to Medicare outpatient revenue."

"Another means of examining effects of BBA changes on hospitals is to forecast lost revenues as the difference between Medicare payment before and after the BBA provisions take effect. All hospital services are threatened if the cumulative impact of the BBA changes force decisions to cease operations or to reduce levels of services (either by dropping services or groups of patients such as the uninsured or Medicare beneficiaries). The impact of the changes in inpatient prospective payment can account for as little as only approximately 1/3 of the reduced Medicare revenue predicted for rural hospitals, as in the case of the example from Missouri hospitals described below; and the conversion to outpatient PPS is not yet included in these calculations. The net impact on rural hospitals is the sum of a number of different payment changes that affect PPS hospitals."

"Some hospitals have estimated annual impacts through the year 2002. Missouri's rural hospitals estimate annual shortfalls to be $32 million in 1998, $45.3 million in 1999, $62.1 million in 2000, $70.4 million in 2001 and $79 million in 2002, from the aggregate total of reduced growth or cuts."

"Rural institutions can only estimate impacts since final decisions about the specifics related to new payment formulas (e.g., prospective payment) have not been made. As a result, the estimates tend to be underestimates because not all possible impacts are considered in any of the calculations. The important question for service delivery to rural beneficiaries and others is can these reductions in reimbursement be absorbed by rural hospitals? While only the test of time could answer the question definitively, an intuitive answer would be no, not without changes in hospital finance and/or organization."

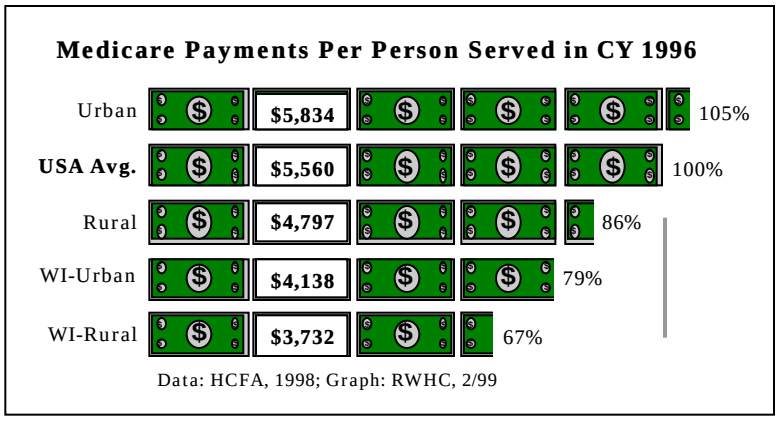
Responses to the Change"

"The payment changes included in the BBA are predicated on the assumption that health care providers and delivery systems can adjust to lower than expected Medicare payment by finding cost savings in their operations. This approach may prove difficult for small rural providers, but not impossible. For example, one

The **Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC furthers the development of a coordinated system of rural health care which provides both quality and efficient care in that best meet the needs of rural residents in a manner consistent with their community values.

Eye On Health Editor: Tim Size, RWHC
880 Independence Lane, PO Box 490
Sauk City, WI 53583
(T) 608-643-2343 (F) 608-643-4936
Email: timsize@rwhc.com
Home page: www.rwhc.com

For a free email subscription of Eye On Health, write office@rwhc.com with "subscribe" on subject line.



home health agency administrator offered the example of introducing 'clinical pathways' for some the most frequent diagnoses, which should result in better and less expensive care. Similar approaches could reduce the costs of other types of care, particularly in skilled nursing facilities and hospitals. The point being made here is that rural health care providers can find and implement measures to reduce per unit costs of care."

"However, individual health care providers are not likely to find sufficient savings to absorb the full amount of payment reductions anticipated as a result of the BBA. Another response is to find savings through developing local networks of service providers. There are programs in place to encourage this activity; the network grant program of the Federal Office of Rural Health Policy, the network grant program of the Bureau of Primary Health Care, and the new State Rural Hospital Flexibility program. Experience with rural networks is still quite limited, and savings cannot be determined. Rural providers may be able to find savings through further development of local and regional networks, but this requires time and the yield is unknown."

"Another possibility for finding cost savings is to increase volume of service per provider such that economies of scale would yield savings. Individual rural providers are not likely to be able to do this, nor will small networks. Two possibilities exist: large rural networks, or consolidation of providers. A challenge for rural providers will be how to cooperate across a sufficient number of locations to generate the patients needed to use new techniques of medical and administrative management, without sacrificing local autonomy."

"*Policy Issues*"

"Policy makers examining the Medicare program are obligated to be fiscally prudent in setting payment policies, but they are also charged with the responsibility of doing what they can to assure that services are available to the beneficiaries. These twin responsibilities pose what has become a core dilemma in recent years meeting an obligation to finance services without spending more than is affordable in the context of the Medicare Trust Fund and the General Fund of the federal budget. The imperative to constrain Medicare spending cannot be met by imposing continuing and significant payment reductions on small rural providers; doing so jeopardizes access to care for rural beneficiaries. Those providers should be able to cut costs in a manner that contributes to savings deemed necessary for the future of Medicare, but not at the same levels as larger providers."

"Therefore, we close with the following considerations for public policies:"

"Any changes in payment policies should include a 'rural differential,' accounting for different impacts on providers as a function of size and location,"

"Policies designed to encourage change in the organization of health care services should include resources and suggested models that encourage rural providers to participate in the changes."

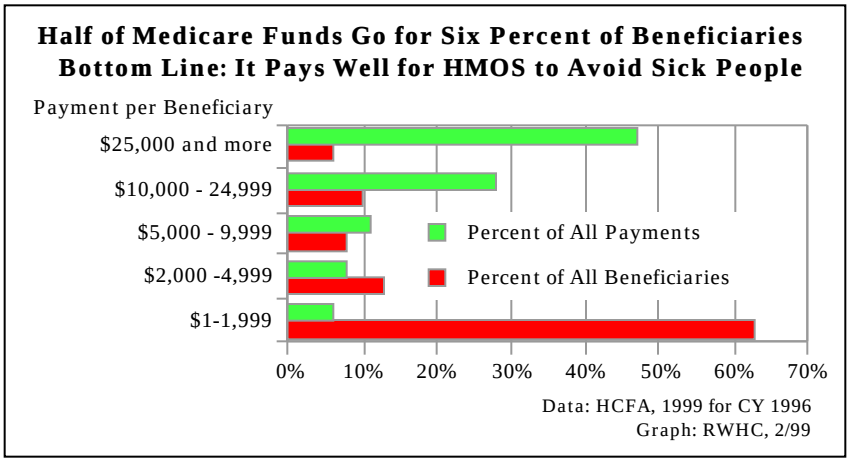
The complete report is available online at <www.rupri.org>.

HMOs Will Have Less Incentive to Avoid Sick

From HCFA Press Release, "Medicare Managed Care Risk Adjustment Method Announced," 1/15/99:

"Health and Human Services Secretary Donna E. Shalala has announced that the Health Care Financing Administration (HCFA) will begin implementing, on a phased-in basis, a more accurate payment method that will assist Medicare managed care plans that enroll the sickest beneficiaries."

"The new payment method -- known as risk adjustment -- will for the first time begin to reflect the health status of Medicare beneficiaries. The new approach, which will be phased in over five years, will increase



payments to plans that care for the sickest beneficiaries who stand to gain the most from managed care's focus on coordinating care. Medicare currently pays health maintenance organizations (HMOs) and other managed care plans a fixed monthly amount per beneficiary, adjusted only by demographic factors."

" 'There is widespread agreement among health care experts that risk-adjusted payments will pay plans more fairly and reduce incentives for plans to enroll only healthier beneficiaries,' Secretary Shalala said."

"Risk adjustment looks at a person's diagnosis in one year and predicts how much, if any, additional cost there will be for that person the next year. For example, a person who has appendicitis in one year is not expected to have higher than average costs the following year. If a person has a stroke, however, additional costs beyond the average are predicted and a plan would receive a larger payment to cover the additional expected costs."

"As required by law, risk-adjusted payments to plans will begin Jan. 1, 2000. However, to ensure that plans have time to adjust to the new payment method, HCFA built a five-year transition period into the risk adjustment methodology it adopted. In 2000, only 10 percent of a plan's payment for each beneficiary will be calculated based on the new risk adjusters, while 90 percent of the payment for each beneficiary will be based on the current system. The full effects of risk adjustment will be phased in between 2000 and 2004."

"Of Medicare's 39 million beneficiaries, over six million are in managed care and over 32 million are in traditional Medicare. On average, 65,000 Medicare beneficiaries enroll in managed care plans every month."

"Currently, Medicare pays health plans a fixed monthly payment for each beneficiary based largely on fee-for-service Medicare costs in each of the nation's more than 3,000 counties. The payments are adjusted by demographic factors such as age, sex, and whether a beneficiary is eligible for Medicaid in an attempt to better reflect the likely future costs of caring for individual beneficiaries. Risk adjustment adds diagnostic information to the payment calculation and significantly improves the accuracy of predicting expected costs."

Health Plans Get Boost in Some Counties

From BNA's *Managed Care Reporter*, 1/27/99:

"Medicare managed care plans in 60 percent of the nation's counties will receive a blended payment rate in 2000, the first year the new methodology will take effect, Nancy-Ann DeParle, administrator of the Health Care Financing Administration, said on January 19th."

"Under the Balanced Budget Act of 1997, county payment rates are based on the higher of a minimum floor payment, a 2 percent increase, or a blend of area specific and national rates."

"Based on current law, the blend will comprise 74 percent of the county rate and 26 percent of the national average. The blend will reach a 50/50 split by 2003 and thereafter."

"The blended rate is calculated to shift payment from local county rates, which vary widely across the country, toward a national average rate. Blending is designed to reduce rates in counties where payments historically have been higher than the national average rate, and increase rates in counties where payments have been lower, according to the Medicare payment Commission."

Wisconsin Note: That "the blend" is now being funded will help Dane County (Madison) but not effect most rural counties, which are expected to remain at the floor. And, many rural experts do not feel that the floor, as currently calculated, is high enough to support managed care as a viable alternative in most rural counties.

Play to Strengths, Address Weaknesses

From "Hospitals, Heal Yourselves," an editorial by Jerome P. Kassirer, M.D. in *The New England Journal of Medicine* -- 1/28/99

"Teaching hospitals are beset by a litany of now familiar complaints. They are often described as large and impersonal. Their expert clinician-professors are said to be aloof and uncaring. House staff rotate off services just when patients are beginning to feel comfortable with them. Personnel often disregard patients' dignity. Appointments are difficult to arrange, their locations are increasingly difficult to find, and the waiting time to see doctors is often excessive."

"Nevertheless, there is a general assumption that the teaching hospitals provide better care than nonteaching hospitals. They have a greater concentration of clinical expertise, a focus on clinical research, and technological superiority. They also score better in the national analysis of the quality of hospital care performed each year by the respected National Opinion Research Center at the University of Chicago and published as 'America's Best Hospitals' in U.S. News & World Report. In these analyses, the teaching hospitals regularly head the list."

"Yet nonteaching hospitals have changed considerably over the past several decades. Trainees from the teaching hospitals, most of them board-certified, now constitute the clinical staffs of nonteaching hospitals, and with only a few exceptions (such as transplantation),

the nonteaching hospitals have narrowed the technological gap. Thus, even without extensive data, one would guess that any differences in the quality of care between teaching and nonteaching hospitals would be rather small and difficult to quantify. Compounding the difficulty of such an analysis are the still unresolved problems of accurately measuring the quality of care received by hospitalized patients."

"In the 1998 'America's Best Hospitals' report, academic hospitals dominated the list, and several teaching hospitals in Massachusetts scored among the best."

"In a study by the Picker Institute sponsored by a consortium of hospitals, health maintenance organizations, businesses, and the Massachusetts Medical Society, the nonteaching hospitals came out on top. (8) The major teaching hospitals, which had such an exemplary record in the study of 'America's Best Hospitals' scored substantially lower than many hospitals with a nonteaching or a minor teaching role."

"Although a few media reports missed it, the explanation of the difference in results was immediately apparent. The Picker study assessed exclusively how patients viewed their hospitals. It sampled patients' perceptions of how adequately hospitals handled their emotional needs, whether they were given adequate information, whether their discomfort was adequately treated, whether care was coordinated, whether they had adequate continuity of care, and whether their families were adequately involved in their care. By contrast, 'America's Best Hospitals' is based on an extensive data base of "structure, process, and outcome" variables including staff-to-bed ratios, availability of high-technology equipment, mortality rates, and nominations by randomly selected board-certified physicians. These divergent reports show quite clearly that both the teaching hospitals and the nonteaching hospitals still have much to learn about providing high-quality care, and they put into sharp focus the kinds of improvements in quality that each must achieve."

"Teaching hospitals must deal with the adverse consequences to patients of concentrating too exclusively on their special responsibilities in research, teaching, and technological development. If the Picker Institute's analysis of Massachusetts hospitals is relevant to other parts of the country (and I am inclined to believe it is), then nonteaching hospitals have a substantial edge over teaching hospitals in many of the human dimensions of care. The short rotations of both house staff and attending physicians in teaching hospitals often result in discontinuity of care and deficiencies in patient education and emotional support. The involvement of medical students, residents, and multiple consultants takes time and sometimes interferes with an orderly decision-making process. Appointments with specialists may be delayed for weeks or even months. Patients still endure long waits for procedures and ungracious treatment by rushed attendants in understaffed day-surgery areas and emergency rooms."

"At the same time, nonteaching hospitals cannot be satisfied with their high levels of patient satisfaction when their standards of clinical practice are substantially below those of teaching hospitals. Nonteaching hospitals have much to learn from teaching hospitals about these essential aspects of care. The studies in this issue of the Journal and elsewhere show that improving the quality of care in nonteaching hospitals does not necessarily require more equipment or even more specialists. Simply giving the right drug, or even starting treatment at the right time, can mean the difference between suffering and health, life and death. If on-the-spot house staff contribute to the excellence of such decisions in teaching hospitals, increasing the number of full-time physicians in nonteaching hospitals might make up for this difference."

"We must redouble our efforts to give optimal care within the constraints of our budgets. Simple changes in our practices and procedures are often all that are needed. We must continue to polish our methods of assessing all dimensions of the quality of care, be willing to make the results public, and act on them decisively. We still have a long way to go."

Telemedicine--Beyond Email

The following is from "First Steps Toward Telemedicine Reimbursement" found at <http://telehealth.hrsa.gov/>, web site for the new Office for the Advancement of Telehealth (OAT) of the federal Health Resources and Services Administration (HRSA). According to Director Dena Puskin, OAT will be adding a new indepth paper on telemedicine to their web site each month so check back frequently. [Or Contact OAT, 979 Rollins Avenue, Rockville, MD 20852, voice/301-443-0447; fax/301/443-1330]

"The new Health Care Financing Administration's (HCFA) telemedicine reimbursement rule is a notable change for the Medicare program. The program raises some critical questions for policy makers, practitioners and telemedicine networks on how best to pay for telemedicine services. As policy makers, practitioners and telemedicine service providers sift through the new regulations, several key issues have emerged about which services will be covered, which health care practitioners can take part in a consultation and what kind of telecommunications technology can be used."

"While telemedicine technology has made it easy to deliver health care services over a distance, few payers are covering these services. Currently, at least 11 state Medicaid programs and several Blue Cross/Blue Shield plans and some other private insurers pay for telemedicine services. Several other states have also recently passed laws requiring all insurers to pay for telemedicine services. Medicare, however, has been more cautious. Prior to enactment of the Balanced

Budget Act (BBA) of 1997, Medicare did not have an explicit policy to pay for telemedicine services. Nevertheless, telemedicine services that did not traditionally require face-to-face contact between a patient and practitioner, such as EKG or EEG interpretation, teleradiology, and telepathology were covered under Medicare in most areas of the nation, in accordance with individual Medicare carrier policies."

"The passage of the BBA required Medicare to pay for telemedicine consultation services using interactive video (i.e., teleconsultation) in rural "Health Professional Shortage Areas" (HPSAs) by Jan. 1, 1999. This signaled a major change in policy. The legislation limits eligibility for coverage to rural HPSAs and prohibits payment for line charges or for facility fees. In addition, Medicare payment is set at the consultant's fee schedule and requires referring and consulting practitioners to share the payment. The final regulation, which was published in the Federal Register on Nov. 2, 1999, explains how Medicare initially will pay for these services and which services will be covered."

"The Medicare final rule on teleconsultation specifies that these codes can be used for a number of medical specialties, such as cardiology, dermatology, gastrology, neurology, pulmonary, and psychiatry. According to HCFA, it will cover additional consultations for the same or a new problem if the attending physician or practitioner requests the consultation, and if it is documented in the medical records of the beneficiary."

"The BBA mandates that consulting and referring practitioners share payments. HCFA requires that 75 percent of the fee go to the consultant and the remaining 25 percent go to the referring practitioner. HCFA came up with this split based on the relative work for practitioners at both ends. (*Editors note: There is substantial disagreement by rural providers about this rationale.*) There was also an inherent recognition that different consultations call for different levels of effort. As a result, the fee split reflects the projected level of new work done by each practitioner over the course of various teleconsultations."

"HCFA's payment policy was developed to replicate a standard consultation as closely as possible. Under Medicare, a separate payment for a consultation requires a face to face examination of the patient. This requirement is consistent with the American Medical Associations description of a consultation. To that end, Medicare's teleconsultation rule requires a certain level of interaction between the patient and consulting practitioner because it offers the best substitute for a "face-to-face" consultation."

"Regardless of the technology, the patient must be present during the consultation. That is because Medicare does not currently make separate payment for the review and interpretation of a previous examination or dermatology photos. Thus, this policy may preclude the use of standard store-and-forward technologies. In most store-and-forward applications, a practitioner at the remote site will typically examine the patient and send a video clip or a photographic scan, along with the patient's medical record to a distant consulting practitioner. The consulting practitioner will then review the file and make a diagnosis. Medicare will not cover this type of telemedicine application because it does not allow for live interaction between the consulting practitioner and the patient and the referring practitioner at the rural site. Medicare will cover some uses of store-and-forward technology as a consultation if the patient is present and there is real-time video and audio interaction level of video or audio interaction between the consulting practitioner and the patient."

"Medicare's telemedicine reimbursement rule represents a significant departure in policy for Medicare and how it pays for telemedicine services. Consequently, this new rule may undergo some changes in the years to come. The Secretary of Health and Human Services has asked HCFA to reexamine some key points, including what services are covered, which medical professionals are eligible to present the patient, and uses of store-and-forward technology. The Department will develop recommendations for Congress within the next year on modifications to the reimbursement rule."

WI Providers Need to Help "Sell" BadgerCare

From a letter by Peggy Bartels, Administrator WI Division of Health Care Financing, 1/28/99:

"On July 1. 1999, we will begin taking applications for BadgerCare families. All families with children who have income below 185% of the federal poverty level (FPL) and who do not have insurance will be encouraged to apply. Prior to that effort, we will also take additional Medicaid outreach initiatives to assure that children now eligible for Medicaid are enrolled."

"BadgerCare benefits will be identical to the comprehensive package of benefits and services covered by Wisconsin Medicaid. The existing Wisconsin Medicaid HMO managed care system will be used."

"Families with income above 150% of the FPL pay a monthly premium of 3.5% of family income. BadgerCare premiums will be collected through wage withholding or an alternative, automated system. families who fail to pay the required premium are subject to a restrictive enrollment period of not more than six months, with exceptions provided for 'good cause.' "

"Once enrolled, families may remain in BadgerCare until family income exceeds 200% of the FPL. No asset test is required."

"BadgerCare fills gaps between Medicaid and private insurance without supplanting or "crowding out" pri-

vate insurance... BadgerCare will require that applicants have no private group insurance for the three-month period prior to enrollment; families with access to insurance where the employer pays at least 80% of the cost of family coverage will be ineligible." (*Editor's note: whether "crowding out" will become a critical problem is very much an open question in some* quarters.) "

"If BadgerCare enrollment is projected to exceed budgeted enrollment levels, a new enrollment threshold will be established for new applicants. The state will provide a minimum of 30 days public notice to any change in the income threshold."

Contact: Angela Dombrowicki at (608) 266-1935 or dombra@dhfs.state.wi.us

Doc Hollywood, Part II

Dr. Jim Hotz, the inspiration for Neil Shuman's "Doc Hollywood" character, (played by Michael J. Fox in the 1991 movie) is a member of the National Rural Health Association (NRHA). Hotz, along with co-author O. Victor Miller has written a sequel, *Where Remedies Lie,* with profits being donated to NRHA.

"In Where Remedies Lie, the people of Grady County must learn to trust a new, young doctor just as Otis Stone, M.D. must adjust to the very different afflictions and remedies of rural medicine. He deals with problems ranging from a patient who usually sees the town veterinarian to treat a poisonous snake bite to the for-profit entity trying to buy out and convert two area hospitals."

"The transition from the rural family doctor who cared for an entire community to a modern care system that utilizes government programs and embraces the concept of networking is a story that has been played out across America's rural communities."

Where Remedies Lie can be ordered through the NRHA for $25, plus $3.50 S&H through the Publications and Resources section of their web site at <www.NRHArural.org>.

Tools For A Healthy Future

National Rural Health Association
22nd Annual Conference
May 27-29th, 1999
San Diego, California

The nation's largest gathering of rural health professionals, featuring:

New shorter three day format

Awards dinner and dance to celebrate the achievements of our colleagues in rural health

Technology Learning laboratory

Roundtables--facilitated interaction/exchange.

BECK WEATHERS, MD: Mt. Everest survivor
NANCY DICKEY, President, AMA
CLAUDE FOX, Administrator, HRSA

For more information call Carlos McClain at (816) 756-3140 or visit www.NRHArural.org

The National Rural Health Resource Center

The following is from The National Rural Health Resource Center (NRHRC) <www.ruralcenter.org/nrhrc>; they also can be contacted at 218-720-0700. NRHRC is administered by the Minnesota Center for Rural Health and partially funded by the federal Office of Rural Healthy Policy.

"Rural Providers and their communities should be knowledgeable about managed care and the impact it may have on local health systems. Will patients' choice of health care providers remain the same? Will small business be able to continue to provide health insurance to their employees? Will residents be forced to travel to urban areas for services currently available locally? An organized, informed community will be better prepared to retain control in the decision-making processes regarding these important issues. Information and education on managed care models are currently available and may be crucial for future success."

"Rural health organizations need to be networked with other organizations both within and outside of their local communities. Our networking technical assistants are able to develop economies of scale and integration of effort, as well as expanded access to new resources such as medical information and telecommunication. We have examples of models that are working in rural communities and are developing assessment tools which will assist in the early stages of evaluation and design of your network."

Rural Youth Injury Prevention Seminar

June 7 - 9, 1999, Marshfield, Wisconsin

Join professionals who work in prevention

Phone 1-888-924-7233, email oertelm@mfldclin.edu or visit www.marshmed.org/nfmc/children/

When We Knew How to Write a Memo

Before Shakespeare's curmudgeonly good name is tarnished any further by the movie industry, it seems appropriate to balance the record. I received the following last year from a North Carolinian gentleman of high stature who needs to remain anonymous. To construct a Shakespearean insult, combine one word from each of the three columns below, and preface it with "Thou":

Column 1	Column 2	Column 3
artless	bat-fowling	apple-john
bawdy	beef-witted	baggage
beslubbering	beetle-headed	barnacle
bootless	boil-brained	bladder
churlish	clapper-clawed	boar-pig
cockered	clay-brained	bugbear
clouted	common-kissing	bum-bailey
craven	crook-pated	canker-blossom
currish	dismal-dreaming	clack-dish
dankish	dizzy-eyed	clotpole
dissembling	doghearted	coxcomb
droning	dread-bolted	codpiece
errant	earth-vexing	death-token
fawning	elf-skinned	dewberry
fobbing	fat-kidneyed	flap-dragon
froward	fen-sucked	flax-wench
frothy	flap-mouthed	foot-licker
gleeking	fly-bitten	fustilarian
goatish	folly-fallen	giglet
gorbellied	fool-born	gudgeon
impertinent	full-gorged	haggard
infectious	guts-griping	harpy
jarring	half-faced	hedge-pig
loggerheaded	hasty-witted	horn-beast
lumpish	hedge-born	hugger-mugger
mangled	hell-hated	joithead
mewling	idle-headed	lewdster
paunchy	ill-breeding	lout
pribbling	ill-nurtured	maggot-pie
puking	knotty-pated	malt-worm
puny	milk-livered	mammet
qualling	motley-minded	measle
rank	onion-eyed	minnow
roguish	plume-plucked	miscreant
ruttish	pottle-deep	moldwarp
saucy	pox-marked	nut-hook
spleeny	rough-hewn	pigeon-egg
spongy	rude-growing	pignut
surly	rump-fed	puttock
tottering	shard-borne	pumpion
unmuzzled	sheep-biting	ratsbane
vain	spur-galled	scut
venomed	swag-bellied	skainsmate
villainous	tardy-gaited	strumpet
warped	tickle-brained	varlet
wayward	toad-spotted	vassal
weedy	unchin-snouted	whey-face
yeasty	weather-bitten	wagtail

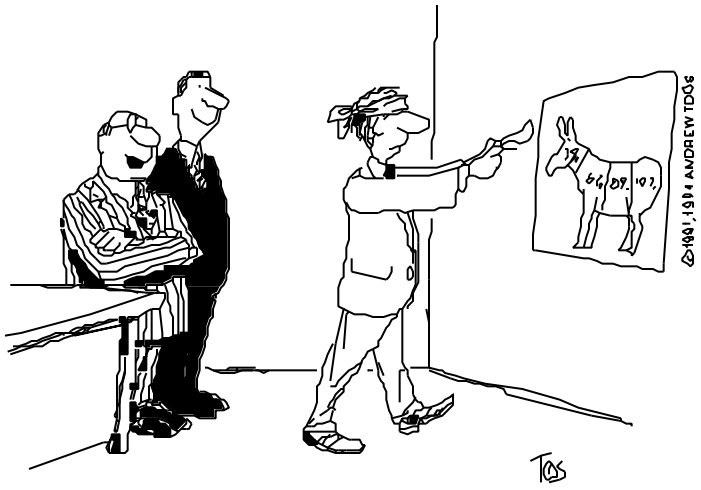
RWHC Members In News Doing Good

Stoughton Hospital--"Stoughton is renowned for its strong sense of community... a case could be made that one of the key reasons we have such a strong sense of community here is the presence of Stoughton Hospital. Some people choose to live here because they fully realize that Stoughton is a small community with big-city amenities, not the least of which is a hospital offering quality, comprehensive care. It's the large employers like the hospital that help make Stoughton a city unto itself and not merely a bedroom community to Madison." (*From Stoughton Courier Hub*, 12/3/98)

The Monroe Clinic--"The Outstanding Business of the Year was awarded to the Monroe Clinic for its continual involvement in community development and community service. Green County Development Director Anna Ragains said the Clinic is continually supportive to businesses and communities in Green County. 'They continually go over and beyond the call of duty.' Most recently notable, she said, was the Clinic's donation of a facility to Rainbow Childcare." (From the Green County *Times*)

Mile Bluff Medical Center, Mauston--"The establishment of a Dialysis Unit is making life easier for dialysis patients. Paul Mullens of Friendship was the first patient to be treated at the new unit. 'The trip to Madison was about 170 miles round trip plus 3 1/2 hours for dialysis and 15 minutes of preparation,' he said. 'It bothers me a lot to be so dependent on my family, so I really appreciate the fact that it will save them some time and miles.' The Unit is able to serve nine patients at once; Brian Ewert, M.D., a Nephrologist from the Marshfield Clinic serves as Medical Director for the Unit." (From *Mile Bluff Times*, 2/99)

RWHC - Eye On Health



"**Beats the heck out of sharing performance data.**"