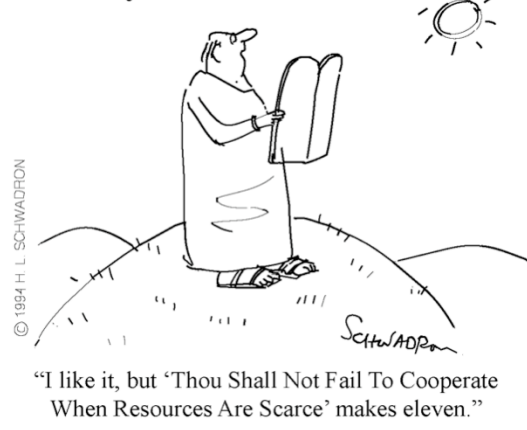




“A Rural Perspective on Physician Workforce Planning”

RWHC Eye On Health



Tim Size
Executive Director
Rural Wisconsin
Health Cooperative
for the
WHA Board
Planning Session
July 23rd, 2009



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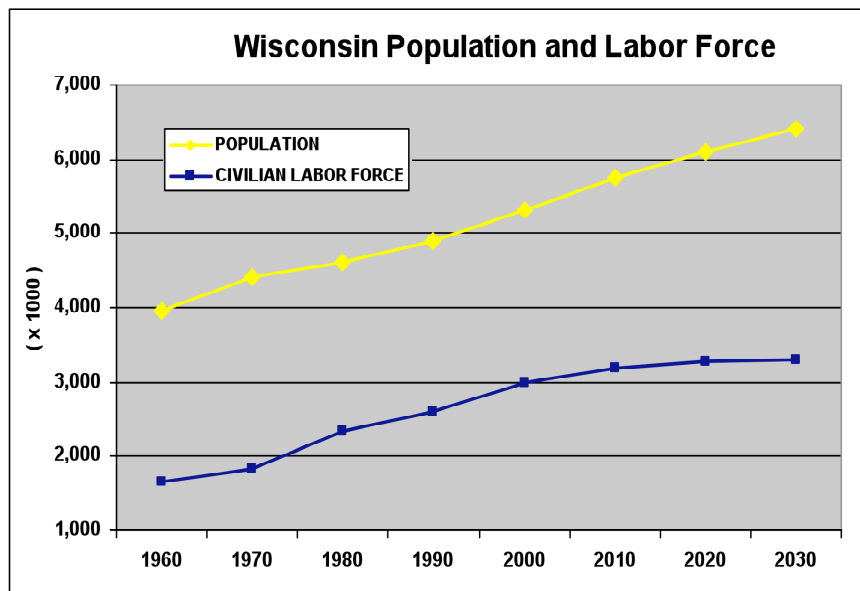
Crisis Now Unavoidable—Not Just Physicians

“The United States faces a looming shortage of many types of health-care professionals, including nurses, physicians, dentists, pharmacists, and allied-health and public-health workers. The results will be felt acutely within the next ten years. Colleges and health science programs will all be affected by demographic, technological, and bureaucratic trends driving the pending crisis... **The final crucial factor precipitating the health care workforce crisis is a lack of comprehensive workforce planning on the parts of academe, government, and the health care professions.”**

Chronicle of Higher Education, 11/07



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Dennis Winters, Chief, Office of Economic Advisors, WI Department of Workforce Development 9/07

Rural* Most Vulnerable to Poor Planning

- Across all healthcare professions, we have **limited statewide supply/demand forecasts** to adequately inform decisions regarding the preparation, retention, and distribution of a sufficient workforce.
- **Consequently**, educational programs have **greater challenge to attract state resources needed to significantly expand the number of graduates.**
- Efforts to gather and analyze data on labor markets and distribution of health professionals are uneven across the state and **we particularly lack good forecasts for supply and demand at regions within the state.**

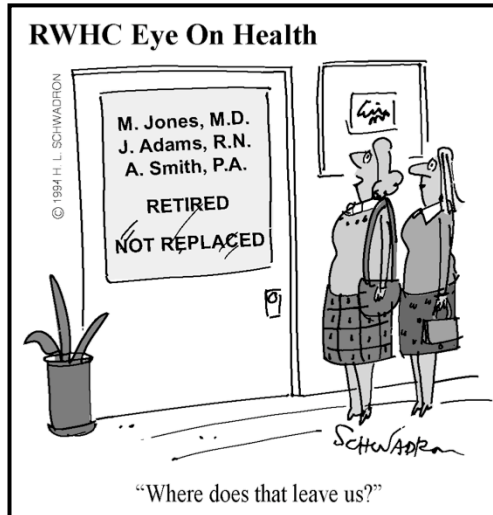
* and inner portions of large cities



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Statewide Average Estimates Insufficient



"When it rains in the suburbs, expect a tsunami in rural and the inner-cities."

Wisconsin Academy of Rural Medicine & Training in Urban Medicine and Public Health exist only due to focus on regional maldistributions.



Stress re Rural Physician Shortages (1 of 3)

While more than 20% of Americans live in rural areas, only 9% of physicians practice in rural locations. Rural America has long struggled with a shortage of physicians and as shortages spreads into urban areas, the rural shortage is becoming more intense. Wisconsin faces the same challenge and it is predicted to get a lot worse before it gets better.

Due to the numbers of jobs available, the shortages are mostly in Primary Care (both Family Medicine and Internal Medicine). However, the growing shortage in General Surgery is particularly troubling given their critical role with patients needing emergency interventions. Specialists in Orthopedic Surgery and Obstetrics/Gynecology are also already extremely difficult to recruit successfully.





Stress re Rural Physician Shortages (2 of 3)

- The trend to sub-specialization means that **most physicians are being trained for careers that are most often only sustainable in urban centers**. General Internists are about as scarce of a commodity as there is as the vast majority are sub-specializing.
- For general surgery in a rural setting, you are **often recruiting not only basic general surgical coverage but also seeking a candidate that will assume C-Section call responsibilities**.
- When some rural hospitals recruit a **Family Practice physician**, they prefer one that includes OB in his / her practice. This means that the newly recruited practitioner will need to be willing to **both assume the risk of OB without access to an on-site OB/GYN and to assume a call rotation that will require an average call ratio of 1 in 4 shifts** on top of other practice call responsibilities.

RWHC Survey Presented to Injured Patients & Families
Compensation Fund Advisory Committee, 1/20/09



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Stress re Rural Physician Shortages (3 of 3)

- A complicating factor for primary care is the **unrealistic expectations that recent graduates have of rural hospitals**.
- The **ability for rural hospitals to adopt a hospitalist model varies greatly** and is a **significant challenge to recruitment** for those who don't have it, as it automatically excludes a substantial number of recent grads.
- **Urban-based clinics, which also serve rural areas with visiting specialists, staff the city needs first** and the rural areas literally “do without” until someone can be found to travel.
- **Waiting time in rural areas for specialty appointments with visiting specialists is increasing; this is true even for appointments provided via telehealth.**

RWHC Survey Results Presented to Injured Patients & Families
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Rural Use of AHPs Mixed

- **Some reported a dramatic shift to the use of Advanced Health Practitioners (AHPs) but in other sites use is limited.**
- **Some older often more complicated patients retain a marked preference and possibly need to see a physician.**
- **Increasingly PAs are being hired into subspecialty practices and not entering primary care or underserved regions.**
- **CRNA coverage is very difficult.**
- **The increasing number of AHPs does not help with call coverage in most cases, placing additional pressure on the fewer physicians in the mix.**
- **Currently one physician can only supervise two PAs at a time and with fewer doctors and a higher dependence on PAs, this may become an additional problem.**

RWHC Survey Results Presented to Injured Patients & Families
Compensation Fund Advisory Committee, 1/20/09



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Can't Wait for Better Forecasts to Act

- **Act on the urgency for health workforce data analysis (including collection) and forecasting to maximize downstream the use of limited development funds.**
- **Plan collaboratively across schools & disciplines.** Multiple key stakeholders bring different perspectives on workforce needs and different resources critical to defining the problems and developing strategies to address them.
- **The crisis is now unavoidable given the late start of our national and state interventions—our opportunity is to limit is depth, destruction and duration.**

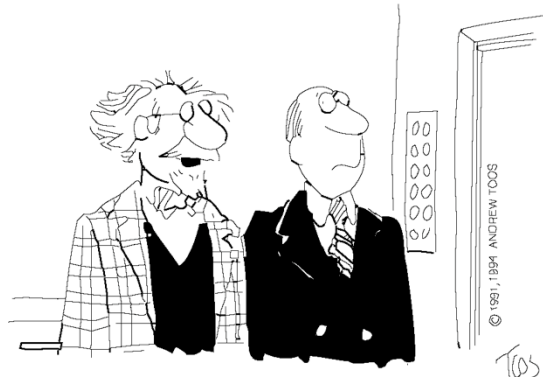


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The Great Lie: Education is Value Free

RWHC Eye On Health



“Our thoughtful ivory tower
is their irrelevant citadel.”

Schools need to
recruit, admit,
educate and
mentor to help
increase (and
not decrease)
the odds for
recruitment and
retention in
underserved
communities.



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WARM Enough? 25 MDs/Yr by 2015

- Applicants limited to Wisconsin residents.
- Bright, accomplished and rural community focused.
- A rural core curriculum is integrated into all four years of medical school: Yr 1 Clinical experiences can be done in smaller communities near Madison.
- WARM students participate in the Rural Health Interest Group to learn about topics relevant to rural medicine.
- An “Overview of Rural Health” offered during the second year introduces key concepts of rural medicine and prepares students for clinical work in rural Wisconsin.



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Warm Students “Outstate” Yrs 3 & 4

- **Regional and Rural Learning Communities:** “Marshfield Clinic and its clinic in Rice Lake begins hosting the first group of WARM students beginning in July 2009. Gundersen Lutheran in La Crosse will host students beginning in July 2010 and Aurora BayCare in Green Bay will host WARM students beginning in July 2011. Sites are affiliates of UWSMPH and are a part of the school’s ‘statewide clinical campus.’ ”
- **Student-Centered Curriculum:** “The WARM program will ensure that its students are meeting the same goals and objectives and competencies that the traditional program requires. This will be done while tailoring students’ experiences to meet their career interests. WARM curriculum is structured to provide hands-on learning and students will learn a variety of clinical skills relevant to rural practice.”

WARM Brochure, 2008



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But WARM Fails Without Rural Residencies

- **Create Incentives for Rural Residency Programs** in Primary Care and General Surgery in rural area. Increase cap on rural residency training programs in primary care and general surgery by 30%. (To qualify, training must occur at least 6 months in a rural location.). Provide appropriate funding for faculty to train additional residents. Create an incentives for primary care:
 - ♦ Interest-free loans if residency is in primary care or general surgery and residency is in a rural underserved location;
 - ♦ Tax credit on income if residency is in primary care or general surgery and residency is in a rural underserved location.
- **Fully implement Rural Training Track** established by Congress in BBRA 1999. CMS has never approved utilization of RTT claiming that it did not have proper authority because it did not have a definition of “rural training track.” SEE AAFP HANDOUT

NRHA Grass Roots National Health Reform Message, 7/8/09



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The Obvious—We Get What We In\$ent

“Growing physician income disparities are a major driver of student behavior. It does so directly, but also indirectly through messages about prestige, intellectual rigor, need to increase ‘productivity,’ and status. In many academic health centers, primary care is labeled as the revenue ‘loss leader’ rather than as a core function or even producer of downstream revenue. This income disparity explains much of the difficulty in achieving the balance in specialty and geographic physician distribution and will continue to inhibit achieving the workforce needed for better quality, efficiency and equity.”

“Specialty and Geographic Distribution: What Influences Medical Student & Resident Choices?” from The Robert Graham Center, Washington, DC, (AAFP Policy Center), 3/09



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Editorial Comment (With No Disrespect)

RWHC Eye On Health



“Yes, I’m a generalist. I chose
primary care over being a partialist.”



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