Why Rural Graduate Medical Education?

by Kara Traxler, RWHC Director for the Wisconsin Collaborative for Rural Graduate Medical Education

There she stood—real live evidence that doctors who train in rural places often choose to practice in a rural community in lieu of its counterpart, “the big city.” She was in line ahead of me and my family, waiting there with hers to buy tickets to the local theater production. We both live in a community where the humans just might outnumber the cows and cornfields.

I couldn’t help but smile as I remembered our talks early in her residency training at the state’s longest running “rural training track”—a residency program preparing doctors to practice the full scope of family medicine, usually located in a rural community. Both of us are mothers, with children of similar ages, who often commiserated over our busy schedules, the blustery Wisconsin weather, and how the kids did or didn’t like the new band teacher.

Sometimes the conversation encompassed future plans for her practice after residency. Those plans centered mostly on heading back east, to the familiar environment of her urban upbringing. Her comments didn’t come as any great surprise. I understood the pull to return to one’s roots, where there are shared memories and a comfort level with the people, culture and landscape.

I wondered if she would begin to feel differently about her future practice location as she got to know our small community. The numbers show she might change her mind. Evidence demonstrates that medical residents who train in rural settings are two to three times more likely to practice in a rural area and that over half of graduates practice within 100 miles of training after family medicine residency. But she was not a statistic; she was a colleague and friend and those numbers were not likely part of her calculation in choosing a future practice location. Her thoughts more likely centered on her current laboring patient, upcoming derm rotation, and In-Training Exam, certainly not on the fact that the local economic impact of her hire into a community would be in excess of a million dollars annually. I doubt she realized yet the boon her practice would be not only to her future patients, but to other retail and service businesses in the area.

As her residency program progressed from year one to year two, she transitioned from training in a mostly urban location with high-volume inpatient rotations, to her rural continuity practice training, which would be the mainstay of her final two years in residency. Here she experienced apprenticeship-style learning.

“Ideas are cheap—making something of them is difficult.” - Anne Sigismund Huff

RWHC Eye On Health, 2/16/15
modeled by doctors with a broad range of knowledge, skills and the procedures needed in a typical rural, resource-limited environment. Occasionally plans for the future would resurface in our discussions. After she’d been in the area a year or so, she commented that maybe Wisconsin would be a good place to practice after all. Plus, the kids liked it here and her husband was settling nicely into his new position.

Later, with continued immersion in her rural training program, she may have become aware that while over 20% of Wisconsin’s population lives in rural areas, only about 10% of physicians practice there. And with the aging population, passage of the Accountable Care Act, increasing rate of physician retirement, and decreasing number of medical students choosing primary care, physician maldistribution has intensified.

While these issues swirled in the healthcare world around her, graduation approached and with it the inevitable decision of where to begin her career as an independent practicing physician. Remarkably, she chose to join the same health care system as her residency, located in a neighboring community. She would work with the physicians she had gotten to know over the years, who had trained, mentored and befriended her. She would start her career in an organization with which she was already familiar, less than a fifteen-minute commute from where her family had begun to grow new roots.

This is just one resident physician’s experience, but her story is not unique. Rural training tracks (RTT’s) are preparing and attracting residents to rural practice all over the country. When Wisconsin rural communities participate in Graduate Medical Education (GME), they provide residents full spectrum medical training, rural immersion experiences, and the confidence to choose rural practice. This leads to increased patient access and the economic growth so critical for a thriving rural community. And it doesn’t hurt the local theater attendance either.

RWHC Takes Rural Wisconsin to Washington

by Jeremy Levin, RWHC Director of Advocacy

On February 4, Wisconsin rural health interests stormed Capitol Hill to meet with nine member offices in our Congressional delegation. Our hardy group of 14 was making these Hill visits in conjunction with the Nation Rural Health Association’s (NRHA’s) 26th annual Rural Health Policy Institute. A group this size can cause space concerns in offices, and elevators!

Our numbers displayed the importance of our visit and the timing couldn’t have been more critical as President Obama’s budget, which was released just two days before our arrival, again proposes cuts to Critical Access Hospitals (CAHs), including a cut in cost-based reimbursement and the elimination of the designated CAH status if another facility is within 10 miles. We started our meetings by talking about the President revisiting these proposals and how other
cuts: sequestration, rural extenders, bed-debt and other types of cuts have already hit rural hospitals hard. We signaled our concerns on how an upcoming debate over the Sustainable Growth Rate (SGR) may put at risk further cuts to rural health care.

Part of our conversations with our delegation also focused on arbitrary CMS regulations, such as: the 96-hour admission hard cap for CAHs as a condition of payment, when the conditions of participation for the CAH program had been changed to an average more than a decade ago; or, the push by CMS to increase the need for direct supervision by a physician for more outpatient services, even when their own advisory panel is determining the level of general supervision is clinically appropriate. Both of these regulations do nothing to improve the level of care nor reduce the cost for the Medicare beneficiary, and unnecessarily complicate the provision of care at a time when the rural health care system has many external stresses upon it.

The bulk of our meetings was also able to focus on workforce and the educational programs and investments that Wisconsin helps support. We expressed disappointment that the President again zeroed out funding for Area Health Education Centers, which provide valuable recruitment and training for quality medical staff to stay in or transfer to rural areas. We had experts that could talk about the Wisconsin Academy of Rural Medicine and Wisconsin Rural Training Tracks.

As I mentioned, many of us were out in DC for the NRHA’s Policy Institute. At those meetings we were engaged by both Congressional leaders and members of the administration from the CMS and HRSA, and we learned from those in the consultant realm something that many of us know, which is that Wisconsin rural hospitals exemplify strength and sound practices in our turbulent times.

We also took the satisfaction in awarding the National Rural Health Association’s Legislator of the Year to Wisconsin’s own Ron Kind.

![Image](image1.jpg)

Insurance “Purgatory”: We Can Do Better

From “Insured, but Not Covered” by Elizabeth Rosenthal in The New York Times, 2/7/15:

“The Affordable Care Act has ushered in an era of complex new health insurance products featuring legions of out-of-pocket coinsurance fees, high deductibles and narrow provider networks. Though commercial insurers had already begun to shift toward such policies, the health care law gave them added legitimacy and has vastly accelerated the trend, experts say.”

“Alison Chavez, 36, who is self-employed, signed up for a marketplace plan in October 2013 that she hoped would be an improvement on her previous plan. She had recently been given a diagnosis of breast cancer and was just beginning therapy, so she was careful to choose a policy on the Covered California marketplace that included her physicians.”

“But in March, while in the middle of treatment, she was notified that several of her doctors and the hospital
were leaving the plan’s network. She was forced to postpone a surgery as she scrambled to buy a new commercial policy that included her doctors. ‘I’ve been through hell and back, but I came out alive and kicking (just broke),’ she wrote in an email.”

“Dr. Alexis Gersten, a dentist in East Quogue, N.Y., switched her family and 11 employees to a new Blue Cross/Blue Shield plan for 2014, after a previous small business group plan was canceled. She bought the plan through a broker, and says she was unaware that it was an Affordable Care Act plan. When her son needed an ear, nose and throat specialist, the nearest was in Albany, five hours away. Though her cardiologist was on the network list, he said he did not take the plan. She ended up driving an hour to see a new one. A dispute with the insurer about how to count deductibles left her with a $457 pediatrician’s bill. This year she has chosen a new policy.”

“‘People may have a checklist when they buy insurance: First, premiums, then the deductible—and those are pretty easy to understand because they’re set dollar amounts,’ said Lynn Quincy, associate director of health reform policy at Consumers Union. But new policies demand different and more difficult kinds of calculations, she said: ‘The terms are unfamiliar, and figuring out networks is especially murky.’

“Compounding the problem is the lack of basic information to shop effectively. When Andrea Greenberg, a New York lawyer, called the help line of Health Republic to clarify the difference between two plans, she found herself speaking to someone reading off a script in the Philippines. ‘I was really outraged,’ she said. ‘This is an important decision with potentially dire consequences. It’s not like you’re choosing a sweater.’

“Likewise, it took many phone calls for Aviva Starkman Williams, a California computer engineer with insurance through her employer, to determine whether the pediatrician doing her son’s 2-year-old checkup was in-network for 2015. Only three of the pediatricians in her doctor’s six-person group were listed in her plan’s online directory, and since her deductible had tripled from the previous year’s, she wanted to limit her out-of-pocket payments.”

“The practice’s office manager couldn’t tell her for sure. The insurer’s representative said he didn’t know because doctors came in and out of network all the time, likening the situation to players’ switching teams in the National Basketball Association. ‘If you don’t have updated information, who does?’ she asked. ‘Isn’t it your job to know?’

“Ms. Quincy said regulators needed to do a much better job setting requirements and policing plan practices and offerings, particularly provider networks. Few states have clear standards and many rely on consumer complaints to ferret out problems.”

“Last month, the California insurance commissioner, Dave Jones, announced new emergency regulations concerning networks, noting: ‘Health insurers’ medical provider directories have been inaccurate, misleading consumers into signing up with a health insurer for access to a doctor, specialist or hospital, only to learn that these medical providers are not actually a part of the health insurer’s network.’

“For now, patients are most often left to fend for themselves. When Amy Moses, a tech entrepreneur in New York City, went online to select a plan, she paid a relatively pricey $650 per month for a United Healthcare plan to make sure her network included a longtime physician. One month into the year, the doctor’s practice was bought by a hospital, which then dropped the plan, so her doctor did as well. (A year later the doctor was still listed in the network directory.)

“She discovered the change only when she contacted the physician for a referral for an urgent outpatient procedure costing thousands of dollars that had been
recommended by an in-network surgeon. (Both the referring doctor and the surgeon had to be in-network for coverage.) ‘I literally had three days to find a new in-network internist and score an appointment to get a referral, or cancel my procedure,’ she said. ‘I was stuck in insurance purgatory.’ ”

Vaccination Failure Hits Children & Taxpayers

From “Measles Outbreaks Cost Taxpayers Millions” by Vanessa McGrady at www.forbes.com, 2/6/15:

“A preventable outbreak of measles creates a social, public health and economic ripple that costs millions of dollars and affects hundreds, if not thousands of people. In 2011, a case of 16 outbreaks across the country that infected 107 people cost an estimated $2.7 million to $5.3 million for just public health systems alone. What’s tougher to tally are the impacts to businesses and families affected by the outbreak, because it depends on the kind of business affected and the income of the families that need to be quarantined or stay home with sick children.”

“At the end of January there were at least 102 cases of measles reported across the country; California has 99 cases alone. A spokesman for the California Department of Public Health says no figures on financial impact for the state’s outbreak are available yet. Last year, more than 600 cases of measles were reported across the country.”

“There are a lot of different ways you could think about the cost of measles,” says Courtney Gidengil, MD, physician at the RAND Corporation who also practices at Boston Children’s Hospital in pediatric infectious diseases and has an affiliation with Harvard Medical School. Those incurring costs include state and local public health departments, hospitals, and families and businesses.”

“Experts estimate that each case of measles costs the public health system upwards of $10,000 to $20,000, but the total estimated cost to taxpayers for one case single patient with measles in 2004 was $142,452. Why so expensive? An Iowa college student traveled to India and came back with measles, sparking a two-month containment effort that involved 2,525 hours of personnel time to review flight manifests, contact exposed passengers, set up vaccination clinics, trace more than 1,000 potentially exposed contacts, and institute and enforce quarantine orders for those who had refused vaccinations. Staffers, on high alert putting in extra time, fielded 2,025 phone calls from concerned Iowa residents and drove 2,243 miles.”

“There are also costs to hospitals,” Gidengil says. ‘Often measles patients will get referred to an emergency room or to a clinic, and then the hospital has to do their own tracing as well and check their health care workers and contact all of the other patients that were there.’ For example, in 2008, an Arizona measles outbreak that affected 14 patients cost two hospitals nearly $800,000. And in 2011, when an unvaccinated Utah high school student traveled to Europe and came back infected with measles, eight others caught the virus. The cost to the Utah Department of Health, Salt Lake Valley Health Department, and Primary Children’s Medical Center calculated the direct cost of staff time, testing, post-exposure vaccines and preventative measures racked up $300,000. Costs for two additional hospitals, a temporary emergency department closure and a school system were not included.”

“For families, the impact comes when a child has to stay home from school, and parents have to stay home or hire help. A Santa Monica, CA, daycare closed Tuesday after an infant came down with a confirmed measles case, leaving parents of 14 infants to figure out alternative childcare or miss work while their children were voluntarily quarantined. Five infants were diagnosed in a Chicago-area daycare, and officials expect more diagnoses to emerge. In 2008, a San Diego boy, whose parents intentionally did not
A commentary by Marie Janz, RWHC Librarian:

I am a health science librarian and super-searcher working with RWHC members through July as part of a grant from the Sewell Foundation.

It has been my experience that when people hear the word librarian, they think of a quiet place with books, computers and a focus on reading. As a health science librarian my focus is not about books, it is about using my knowledge of healthcare databases and my ability to develop structured search strategies to connect those in healthcare to evidence-based information that supports their work taking care of patients.

Research published in 2013 by the National Library of Medicine and the University of North Carolina-Chapel Hill* revealed how information impacts patient care. The study looked at time saved using a librarian to provide literature searches, what aspects of patient care were changed, and what key adverse events were avoided. They surveyed physicians, physician assistants and nurse practitioners. A whopping 75% of respondents reported they handled

A clinical situation differently as a result of information provided by a librarian. When looking at data usually I focus on the big numbers, but what jumped out at me in this study was that 3% of respondents said that a patient death was avoided.

In my work as a health science librarian, I have found research articles for teams developing patient care plans or implementing new programs, I’ve located information for physicians treating patients with rare diseases as well as provided information to executives on current trends in healthcare. I know that I can save people time using my talent to find and synthesize relevant information, but I hadn’t thought about the impact of the information on avoiding key adverse events.

Recently a nurse at a RWCH member hospital asked me to find information on preoperative screening for MRSA. I used my search skills to drill down and found current guidelines, standards and research published by hospitals that were successful in reducing postop infections by implementing preoperative MRSA screening. Postop infections can impact length of stay, reimbursement and, worst case scenario, patient mortality.

It is typical in rural hospitals for one nurse to wear many hats. This nurse manages two specialty departments at her hospital, as well as being responsible for infection control. Her time is focused on managing her staff, making sure her specialty departments are meeting regulatory standards, that the hospital meets infection control standards, and is probably also doing hands-on patient care. When this nurse finds time to review the research provided by the librarian, she doesn’t have to spend time looking through a million google hits–she can be confident that she has current, relevant, evidence-based information that supports implementing preoperative screening at her hospital–making this best practice their standard of practice.

In addition to doing literature searches, I am also helping rural
healthcare professionals learn how to find patient care information using freely-available, credible websites such as PubMed, MedlinePlus and Badgerlink (a state funded resource). Monthly Lunch & Learns are being offered on this topic and each session will focus on a different resource for finding evidence-based clinical information.

These sessions are open to members and non-members and the schedule is available at this site:

http://wilib.blogspot.com/p/lunch-learn-schedule.html

If you are interested in an in-depth training on how to find information, contact me to discuss the possibility of an on-site session or one-on-one training. Information can be powerful and I hope RWHC members will continue to utilize and benefit from this service.

Please contact me if you have any questions or would like to discuss how I can help you access the information you need to support your clinical practice. I can be reached via email at mjanz@rwhc.com or call 715-814-1288.


www.ncbi.nlm.nih.gov/pmc/articles/PMC3543128/

Leadership Insights: “AOMM”

The Leadership Insights series is by Jo Anne Preston, RWHC Organizational Development Manager. Back issues are available at www.RWHC.com.

AOMM? “Acronyms On My Mind. Sometimes acronyms can give us a case of brain freeze or make us feel like the only one who doesn’t know what the letters stand for, but when used effectively, they provide a communication shortcut and sometimes even a bit of humor. Here are three acronyms that are new to me, and some thoughts on their impact on leaders.”

TLDR—“Too Long Didn’t Read. Like packing for a trip, less is generally plenty. Are there a lot of things in your ‘to read later’ pile when you have TIME because they are too long to read NOW? To prevent your writing getting put into someone else’s ‘later’ (or never) pile, try the following:

- Learn to summarize. Strong communicators can boil down a big message to the ‘elevator speech.’ Practice this by writing about a book you have read and getting the core message into a short paragraph.

- Clean up your stories. Stories are powerful, but too much detail and background information exhausts the reader. Think about the needs of the reader first. Then review your writing to meet those needs, cutting out unnecessary details. Have a second person go through it again to streamline it even further.

- Fit emails into a smart phone screen. I used to suggest keeping emails sized to what would show on the computer reading pane without having to scroll down. Habits have changed! If it is important and you want it read, cut it down to phone screen size if it’s likely your reader will see it there.”

CAVE—“Citizens Against Virtually Everything. You know the ones. If you happen to have the opportunity to coach them:

- Give them feedback. If you see them as CAVE, so do others. When people are getting in their own way of being seen as credible, care enough about them to share your observations. Clearly they want to influence but they won’t be effective if they are seen as consistently negative.

- Listen. (Even though we would rather argue with or avoid CAVEs). Often the person who is the loudest and most consistently negative has an unmet need to be heard. Put aside your own agenda
and suggest they tell you more about how they see things and how they came to believe as they do. Then paraphrase your understanding of their point of view. That is not the same as agreeing. It is letting them know that you understand and that you honor their right to their views.

- **Teach persuasion skills.** CAVEs likely want to influence others and there are skills to learn to get better at this than just speaking out against something. *Getting to Yes* and *Getting Past No* are two books you could explore together.”

**R&D – “Rip-off and Duplicate.”** It is a great companion to Research and Development. Some of our best ideas come from others and R&D is a give and take proposition.

- **Give credit.** R&D is not about stealing or copyright infringement. It’s about taking what works and building off of it. It’s a compliment. Thank you Dr. Allen Last, Dr. Clint MacKinney, and NPR for the acronyms in this newsletter that inspired my own R&D.

- **Offer your stuff for R&D.** If it works for you, share it with others. There is certainly competition in healthcare, but if helping competitors is ultimately better for the customer, share. Collaborate. Rising tides raise all ships.”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series 2015 go to www.RWHC.com and click on “Services” or contact Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

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Open to Non-Members. To register or see other events, go to: [www.RWHC.com/Services.aspx](http://www.RWHC.com/Services.aspx)