Narrowing the Rural Urban Divide

by Tim Size, RWHC Executive Director

Katherine Cramer’s book “The Politics of Resentment: Rural Consciousness in Wisconsin...” is required reading for anyone interested in better understanding our country. Well before our current level of partisan animosity took hold, she was interviewing small groups who regularly meet in gas stations and restaurants “outstate” from Wisconsin’s largest urban “centers,” Madison and Milwaukee.

According to Cramer, “listening closely to people revealed two things: a significant rural-versus-urban divide and the powerful role of resentment. This book shows that what can look like disagreements about basic political principles can be rooted in something even more fundamental: ideas about who gets what, who has power, what people are like, and who is to blame.”

Many of the people she listened to around the state “identified strongly as rural people and took it as a given that rural areas do not get their fair share of political attention or decision-making power or public resources and have a fundamentally different set of values and lifestyles, which are neither understood nor respected by city dwellers.”

I first came to Wisconsin in the mid ’70s to work at the University of Wisconsin Hospital and Clinics in Madison. While there, I was asked to do “outreach” to rural hospital administrators in the southwest part of the state— to offer them services that the hospital had become interested in selling. Long story short, after multiple lunches they politely said no thanks but went on to explain what they would find useful.

Over the following year our collaboration led to the incorporation of the Rural Wisconsin Hospital Cooperative (RWHC) in 1979. A cooperative business model was seen as a model well known in rural communities that would allow for a variety of organizations to work together without fear of a loss of control. RWHC has grown to be owned and operated by forty, rural acute, general medical-surgical hospitals, an advocacy and shared services network among both freestanding and system affiliated hospitals.

Katherine Cramer describes what I have long heard from my rural friends and colleagues and what I have learned to expect in all too many instances while trying to represent their perspective and interests. While I am still kidded by my board as that “Madison liberal,” I take comfort in the balance of being seen by my Madison friends as that “rural conservative.”

I do a few cartoons each month for RWHC’s newsletter. A good cartoon can point out the absurd nature of much of healthcare as well as leading to the core of complex issues. Often, I am just writing...
down what I hear and pair it with separately acquired illustrations. I went back over the last year’s cartoons and found that a good third have a sentiment consistent with what Katherine Cramer was hearing.

Here are just a few examples:

- Urban executive: “It is OK to pay rural hospitals less, they can grow their own vegetables.”
- Two rural computer users: “Dial-up access to get rural internet works about as well as your air conditioner during a brownout.”
- Two rural executives: “Only Medicare would penalize rural hospitals for seeing patients with greater needs.”
- Medicare staffer: “We don’t need rural hospitals when we have MASH Tents (Mobile Army Surgical Hospitals.)”
- Rural advocate: “I’ll drop ‘what about keeping local care local’ when you stop saying ‘just trust me.’ ”

Having said all of the above, it is important to note key examples of where thoughtful partnerships have been developed and that can act as a model for the behaviors that are needed to narrow the rural-urban divide, both real and perceived:

The University of Wisconsin-Madison developed with rural partners the Wisconsin Academy of Rural Medicine, a medical school within a medical school that focuses on recruiting students from rural communities and helping them achieve their vision of returning to serve rural communities.

The Medical College of Wisconsin is developing community medical education program campuses in Central Wisconsin and Green Bay. Community advisory boards are being established for both campuses to be engaged in the oversight of the campuses in their region.

Last August, RWHC Members Monroe Clinic and Grant Regional Health Center (Lancaster) welcomed Sean Cavanaugh, Director of the Center for Medicare at the Centers for Medicare & Medicaid Services (CMS) to continue efforts to engage CMS on important rural hospital and healthcare-related issues. While no one left that day feeling we had resolved the longstanding differences between CMS and rural providers, I believe all felt we had taken a step in the right direction and more such dialogue could make a real difference in narrowing the divide.

The following week in Washington, D.C., Eric Borchgerding, head of the Wisconsin Hospital Association, reported Sean Cavanaugh as telling to a national meeting that he had just toured some impressive rural Wisconsin hospitals and that it was a valuable educational experience to “really get on the ground there.”

My take away from nearly forty years working on Wisconsin’s rural-urban divide: bridges get built from both sides of a river and for Wisconsin to succeed ALL of Wisconsin must succeed.

“Small & Independent Remains Beautiful”

From “How I Was Wrong About ObamaCare” by Bob Kocher in the Wall Street Journal, 7/31:

“I was wrong. Wrong about an important part of ObamaCare.”
“When I joined the Obama White House to advise the president on health-care policy as the only physician on the National Economic Council, I was deeply committed to developing the best health-care reform we could to expand coverage, improve quality and bring down costs. We worked for months to pass this landmark legislation, and I still count celebrating the passage of the Affordable Care Act with the president one balmy spring night in 2010 as one of my greatest Washington memories.”

“What I got wrong about ObamaCare was how the change in the delivery of health care would, and should, happen. I believed then that the consolidation of doctors into larger groups was inevitable and desirable under the ACA. I joined my White House health-care colleagues in writing a medical journal article arguing that ‘these reforms will unleash forces that favor integration across the continuum of care.’ We added that ‘only hospitals or health plans can afford to make the necessary investments’ needed to provide the care we will need in a post-ACA world.”

“Well, the consolidation we predicted has happened: Last year saw 112 hospital mergers (up 18% from 2014). Now I think we were wrong to favor it.”

“I still believe that organizing medicine into networks that can share information, coordinate care for patients and manage risk is critical for delivering higher-quality care, generating cost savings and improving the experience for patients. What I know now, though, is that having every provider in health care ‘owned’ by a single organization is more likely to be a barrier to better care.”

“Small, independent practices know their patients better than any large health system ever can. They are going up against the incumbent and thus are driven to innovate. These small businesses can learn faster without holding weeks of committee discussions and without permission from finance, legal and IT departments to make a change.”

“More often than not, one of the most important changes these practices make is embracing technology. The ability to store, analyze and make sense of data has now become so easy and inexpensive that all physicians can use ‘big data.’”

“In my White House days, we believed it would take three to five years for physicians to use electronic health records effectively. We were wrong about that too. At every opportunity, organized medicine has asked to delay and lower thresholds for tracking and reporting basic quality measures; yet they have no reason to delay.”

“In the ACOs run by Aledade, which advises small medical practices (I sit on its board), we have found that independent primary-care doctors are able to change their care models in weeks and rapidly learn how to use data to drive savings and quality. For small practices, it does not take years to root out waste, rewire referrals to providers who charge less but deliver more, and redesign schedules so patients can see their doctors more often to avert emergency-room visits and readmissions.”

“Recognizing the strength in small practices, the federal government needs to write rules that make it easier for them to thrive under ObamaCare and don’t tip the scales toward consolidation. That means introducing payment models that limit losses for small providers to the Medicare dollars they receive rather than total spending, and which rely on multiyear benchmarks instead of single-year swings. It also means comparing small practices to other small ones—instead of to large health systems with large balance sheets—when determining if a practice deserves bonus payments for savings.”

“Large health systems deliver ‘personalized’ care in the same way that GM can sell you a car with the desired options. Yet personal relationships of the kind often found in smaller practices are the key to the practice of medicine. They are the relationships…"
that doctors want to forge with patients, and vice versa. It may sound old-fashioned, but what I have learned is that we do not need to sacrifice this unique feature of our health-care system as we move forward in adapting new value-based payment models and improving the health of patients.”

Dr. Kocher was special assistant to President Obama for health care and economic policy in 2009-10. He is now a partner at Venrock, the venture-capital firm.

WI Looking at 4,000 Physician Shortage

A Press Release from the Wisconsin Council on Medical Education and Workforce, 8/23:

Wisconsin is Making Progress on Physician Shortage, but Warns of a Looming Crisis

Wisconsin has made steady progress to address a projected shortage of physicians in the state, according to a new report by the Wisconsin Council on Medical Education and Workforce (WCMEW). But changes in physician demographics, combined with an aging patient population, suggest much more work is necessary to avoid a future crisis.

WCMEW’s 2016 report, “A Work In Progress: Building Wisconsin’s Future Physician Workforce,” projects a potential shortfall of as many as 4,000 physicians by 2035 and recommends:

- A continued focus on expanding graduate medical education in Wisconsin
- Expansion and improvement of Wisconsin’s education and training infrastructure
- An increased emphasis on recruitment and retention issues
- Ongoing encouragement of care transformation

“Wisconsin has made good progress toward building its future physician workforce,” said WCMEW Executive Director George Quinn. “But that work needs to be redoubled if we are to meet our future workforce challenges.”

Projected Physician Demand and Supply for 2035—The 2016 report projects physician demand increasing 25 percent by the year 2035, dramatically more than Wisconsin’s projected population increase of 12 percent. This is because the over-65 population is projected to increase by 69 percent, and patients over the age of 65, on average, use nearly three times as many physician services as younger patients.

Meanwhile, physician supply is projected to increase by 8 percent, but only if Wisconsin continues to attract, train and retain physicians at the current rate, and if physicians see the same number of patients as they do currently.

A significantly different result occurs if downward trends in the number of patients seen by the average physician continue. If the trend continues, a decrease of 7 percent in full-time equivalent physicians is projected, increasing the shortfall to as much as 4,138 physicians by 2035.

“Changing physician demographics and the increasing complexity of health care delivery and payment is also impacting the clinical output of the average physician,” according to Quinn. “The evolution to data-intensive health care is resulting in higher quality, higher value health care, but that comes at a cost in the form of significant new documentation and administrative responsibilities on physicians. As a result, Wisconsin will need a somewhat higher number of physicians per patient in order to account for decreasing trends in the average physician’s clinical contact hours.”

In 2011, the Wisconsin Hospital Association (WHA) issued a seminal report that projected a shortage of physicians by 2030. The report contained a number of recommendations that were operationalized over the past five years, including:

- Expanded graduate medical education (GME)—A new state-funded GME grant program that has funded 11 new or expanded programs in primary care, general surgery and psychiatry with a total of 73 physicians being trained when it is fully implemented.
**Increased medical school enrollment**—The Medical College of Wisconsin opened two new campuses, and existing rural/inner city programs were expanded by the University of Wisconsin School of Medicine and Public Health (UWSMPH).

**Gained a better understanding of the transformations that are occurring in health care**—WCMEW sponsored two statewide conferences on team-based care in 2014 and 2015 where over 200 clinicians discussed challenges and opportunities in this innovative care delivery model.

“While it has been gratifying to see the progress we have made in meeting our future physician workforce needs, more needs to be done.” said Charles Shabino MD, chief medical officer for the Wisconsin Hospital Association and WCMEW Chair. “Fortunately WCMEW is well-positioned to help shape future health care workforce initiatives.”

The full Report is available at [www.WCMEW.org](http://www.WCMEW.org)

*The Wisconsin Council on Medical Education is a voluntary collaborative, serving as a venue for dialogue, a public platform to highlight health care workforce issues, and a catalyst for creating workforce policy.*

---

**Faces of Wisconsin’s Future Nurses**

The Wisconsin Center for Nursing (WCN) in cooperation with RWHC has developed the video: “Nursing in Wisconsin: Faces of the Future!”

WCN’s mission is to assure an adequate, competent, and diverse nursing workforce for the people of Wisconsin. The goal of this video project is to promote the critical need for increasing diversity within the multitude of roles in the nursing profession. Thanks to all the students who participated. We are all proud to present the faces of the future of nursing in our state:


Special thanks to Chris Brown, RWHC’s Marketing & Multimedia Design Specialist, who took videos from multiple iPhones at a recent nursing conference and made this excellent video promoting men and women going into the increasingly diverse field of nursing.

*Please share the above link through all the websites and social media to which you have access.*

---

**Q&B-RWHC Community Engagement Award**

**Quarles & Brady LLP** and RWHC are pleased to announce the winners of the second annual Quarles & Brady/RWHC Community Engagement Award. The winner of a $2,500 grant is **Upland Hills Health** in Dodgeville, Wis. The second place award of $500 was given to **Columbus Community Hospital, Inc.** in Columbus, Wis. Both awards are provided by Quarles & Brady.

**Upland Hills Health “Just Drive: Focus on the Road”**—Upland Hills Health was recognized for its "Just Drive: Focus on the Road" program, created by the Upland Hills Health Trauma and Prevention Team Nurses in an effort to reduce the occurrence of distracted driving accidents among teenagers. Upland Hills Health partnered with several Iowa County area high schools, presenting information in an assembly format and sharing insights with the students. The most impactful part of the program is a testimonial from a teenager who suffered trauma in an accident because of distracted driving.

Since the program began in 2012, it has received substantial media attention. It also recently expanded to include a partnership with Southwest Technical College. Upland Health will use this grant to purchase a distracted driving simulator for high school and...
Southwest Technical College driver education programs.

Columbus Community Hospital “Operation Overhaul 2.0” – Columbus Community Hospital (CCH) and the Your Better Life Coalition have partnered on the "Operation Overhaul 2.0" program to decrease obesity rates in Columbus, Wis., and Fall River, Wis. CCH professional health instructions go onsite to partner locations to increase employees' and their families' health and wellness through decreasing. This program is specifically tailored to the manufacturing industry to reduce obesity and impact chronic health conditions.

Quarles & Brady LLP is a full-service law firm offering an array of legal services to corporate and individual clients that range from small entrepreneurial businesses to Fortune 100 companies, with practice focuses in health care and life sciences, business law, data privacy and security, and complex litigation. Info can be found online at www.quarles.com.

“Ageism Makes Us Sick”

From ‘Why Ageism Makes Us Sick’ by Diane Farsetta at www.son.wisc.edu/CARE.htm:

“In many ways, ageism is similar to other forms of discrimination. Images, language and widely-held expectations communicate and reinforce negative stereotypes about a large, diverse group of people.”

“How many times have you heard your parents say, ‘Oh gosh, I’m having a senior moment,’ Betsy Abramson asks students at an event organized by the University of Wisconsin–Madison School of Nursing’s Center for Aging Research and Education.”

“It’s not a senior moment,” says Abramson, the Executive Director of the Wisconsin Institute for Healthy Aging. “Haven’t any of you forgotten your keys or your cell phone or where you left your backpack? So why do we attribute a minor lapse in memory as being due to our age?”

“Ageism is unique in that it takes root when people are young and don’t identify strongly with older adults. ‘Unlike race and gender stereotypes, we acquire age stereotypes before they can apply to us,’ explains Abramson. ‘By the time we do reach older age and the stereotypes become more self-relevant, we’ve already internalized them.’ When that happens, many people ‘lack the defenses to ward off the impact of those negative stereotypes and self-perceptions.’”

“People who think health problems are inevitable as they age are less likely to engage in preventative behaviors,” says Abramson. They’re less likely to get blood pressure screenings, to get flu shots, to wear their seatbelts, or to engage in any exercise.” Not surprisingly,” continues Abramson, ‘these negative perceptions about aging become self-fulfilling. These older adults do have higher levels of arthritis, hearing loss and heart disease than those who attribute disabilities to other causes,’ rather than just aging.”

“Research by Becca Levy, PhD, Professor of Epidemiology and Psychology at the Yale School of Public Health, documents how age stereotypes affect older adult health. Positive attitudes towards aging are associated with higher recovery rates from severe disability, improved memory and cognitive function, and lower risk of cardiovascular events.”

“Remarkably, attitudes towards aging affect longevity more than blood pressure, cholesterol, body mass index, exercise or smoking.”
“Those with positive attitudes towards aging increase their longevity by seven and a half years,” says Abramson. “Imagine if there was a virus that shortened everyone’s life by seven and a half years. Wouldn’t we be doing all that we could to stop it? Wouldn’t NIH be pouring money into solving it?”

“Paying attention to the language used to describe aging and older adults is a good first step. ‘Try to catch yourself, every time you describe an older adult and use the words ‘still’ or ‘but’ or ‘despite,’ Abramson suggests. As in, ‘My 83 year-old mother still drives,’ or ‘My uncle is 91 but he’s got all his marbles,’ or ‘Though she’s 85, she’s really active.’”

“If you’re using that kind of language, you’re saying that the older adult who is driving, mentally sharp or active is an exception,’ she adds. ‘You’re saying that the typical older adult is not any of those things.’”

“In addition to avoiding ageist language, ‘It’s really important to be honest about your age,’ says Abramson. ‘It’s important to have friends in all generations. Like having friends from different cultures, it helps you get a richer perspective. It helps you realize that ageism is bad for everyone’s health, from older adults to little kids.”

“Do you have strong feelings about your religious beliefs, making it more natural to advocate one’s own views than to inquire about others. Add to this that current political conversations can quickly lapse into careless comments about religion, and before you know it trust and respect are damaged.”

“This article is not about the legalities of talking about religion at work. It’s about digging deeper into how religion impacts work culture and employee engagement. As a leader, whatever your personal beliefs are, you have a stake in increasing the feeling of employee inclusion. When employees feel a sense of belonging they are more engaged, productive and they stay.”

Avoid assumptions—“Like most communication mishaps (and repeatedly stated in these newsletters because they instigate so many of our problems), assumptions can take a lot of the blame. When it is assumed that people are mostly homogeneous religiously, you can be sure there are employees feeling like they are not part of the ‘team.’ It may not even be that they have a different religion. According to the Pew Research Center, about a quarter (and growing number) of U.S. citizens have no religious affiliation at all, either agnostic, atheist or no religion in particular, and many report feeling negatively judged at work, even if nothing directly is said about it.”

Look and listen—“What religious or spiritual messages are there in your work environment? Does the lunch table conversation regularly revolve around church or a particular religious organization’s activities? Are people encouraged to pray for others or about certain situations? Do only select religious holidays get mentioned or accommodated for? Objectively observe, and ask yourself, ‘Could people who are free to believe differently feel excluded by these kinds of conversations?’ If so, take the lead in more open and inclusive conversations.”

Be who you are—“This is not about being politically correct or having to silence your spiritual self. It is about considering the impact of your words and actions on employees whose work you respect and value. You set a tone as a leader, and you can be both authentic and inclusive. For example, if you are Christian and speaking about something related to that, use ‘I’ instead of ‘we.’ It’s a small word change, but if an employee is not part of the ‘we,’ your comments may have just made them feel not included or negatively judged.”

Religiously affiliated organizations also, be who you are—“It is to be expected that a faith-based insti-
tution proclaim that faith, but also that they most often will need to hire people of any or no religion to carry out their work. Employees need not share the same religious beliefs to respect and carry out the mission. When it comes to leading people, behavior is what people are accountable for, not their personal religious beliefs.”

Be respectfully curious—“With employees who have indicated they have religious traditions different than yours, look for an opportunity to learn more about it. For example, ‘I’m not very familiar with those traditions; I would be very interested in learning more about them.’ They won’t be speaking on behalf of a particular religion, but you will show interest and respect as well as learn more about them, another key to employee engagement.”

Look at your workplace policies—“Review them against the Tanenbaum Religious Diversity Checklist at http://ow.ly/cWjr3034P4D. Start up a conversation with other leaders about one or two ways you can create a more open, respectful culture where all people feel included. When it comes to celebrations, dietary requirements, diversity education, etc., solicit input from staff and make sure everyone has equal opportunity to share their ideas. Tanenbaum also encourages developing an ‘accommodation mindset’ to describe thinking about diversity in a way that creates a welcoming and inclusive culture.

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For info re the RWHC Leadership Series go to www.RWHC.com/Services.aspx or contact Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

<table>
<thead>
<tr>
<th>RWHC Leadership Series Upcoming Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/23  -  At the Heart of the Matter: Engaging Your Workforce</td>
</tr>
<tr>
<td>11/10 - Performance Reviews: Making Them Meaningful, Useful &amp; Useful &amp; Worthwhile (4-hr workshop)</td>
</tr>
<tr>
<td>11/14 - Speak Up! Developing Public Speaking and Presentation Skills (4-hr workshop)</td>
</tr>
<tr>
<td>Non-Members Welcome. Register &amp; other events at:</td>
</tr>
<tr>
<td><a href="http://www.RWHC.com/Services.aspx">www.RWHC.com/Services.aspx</a></td>
</tr>
</tbody>
</table>

Space Intentionally Left Blank For Mailing