

Review & Commentary on Health Policy Issues for a Rural Perspective – February 1st, 2004

Physician Workforce Reform Long Over-Due

From a Guest Editorial, “Wisconsin Can Prepare & Support Rural Physicians,” by Tim Size, RWHC Executive Director in *WMJ*, the Journal of the Wisconsin Medical Society, 12/03:

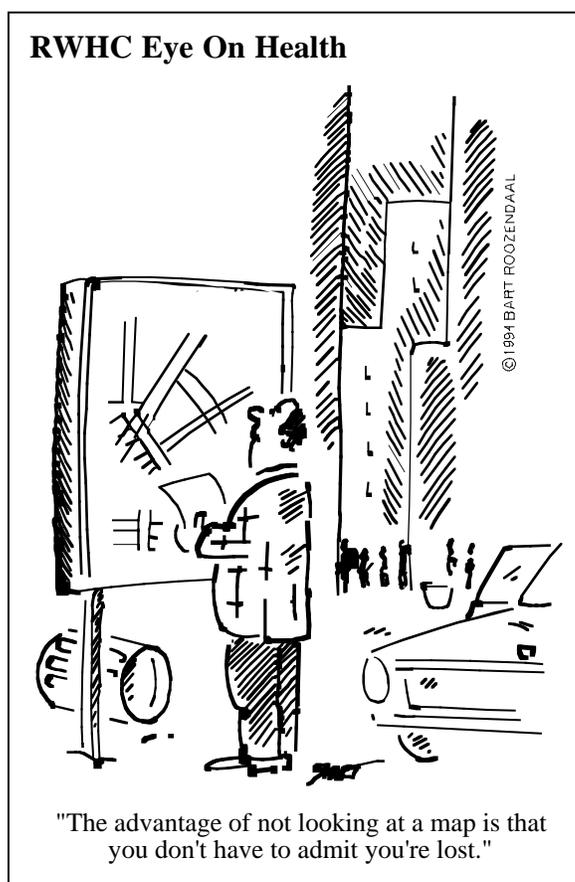
The recently adopted Medicare “reform” bill includes significant assistance for physicians and hospitals in rural communities. For physicians there is a minimum payment update replacing a major cut, additional incentive payments for targeted underserved counties and a floor of 1.00 in the Work Geographic Index.

While both praise and criticism of the prescription drug benefit and competitive demonstration elements of the bill have been overwrought, as befits a very partisan Congress headed into an election, the rural provisions appear to have enjoyed broad bi-partisan support. Years of advocacy, better data highlighting rural problems and more to the point, Congressman from rural states who are now in leadership created a “perfect rural storm.”

Does this bill provide significant help? Yes. Will it solve the current shortage of physicians practicing in Wisconsin’s rural communities? No. As the dust settles, a new generation of federal issues will be identified and moved forward. But all solutions do not come from Washington, DC—there are major steps we can and must take here at home.

Over the last year, national experts have begun a debate about whether America is heading into a serious national physician shortage. However, there is no ar-

gument about the fact that Wisconsin has been experiencing for years a major shortage of physicians in its rural (and inner city) communities. The Wisconsin Office of Rural Health lists 60 federal Health Professional Shortage Areas, all but a handful being rural. Given the graying of the physicians currently working in rural Wisconsin communities, the shortage will get worse before it gets better without a concerted statewide effort. Here are several key building blocks for a comprehensive statewide strategy:



“We make our decisions, and then our decisions turn around and make us.” F.W. Borum (a nineteenth-century writer) quoted by David Maraniss in *They Marched Into Sunlight: War And Peace, Vietnam And America, October 1967.*

Medical Education—The attributes of medical students and programs that lead to graduates choosing family medicine and other specialties for rural practice are well known. One of many articles on the topic is by Howard K. Rabinowitz, MD, and colleagues, “Factors for Designing Programs to Increase the Supply and Retention of Rural Primary Care Physicians,” (JAMA, 9/01). They indicate the critical importance of a strong institutional mission (not just lip service), a focus on primary care, targeted selection of students, early clinical experiences and community-based training outside the institution.

Neither our State nor our medical schools have committed to specific targets regarding the proportion of their graduates who will choose to practice in rural and other underserved Wisconsin communities. To deny the role of the medical school admissions process, faculty attitudes and off-campus training experiences in effecting where graduates choose to practice is to deny a wealth of published research to the contrary. Bottom line, its hard to hit a target we haven’t set.

We must develop a public-private sector “agency” in Wisconsin that has the primary responsibility to keep physician shortage and distribution planning in the limelight and serves as a forum for tracking the progress being made or not towards meeting physician supply and distribution targets.

No discussion about the future of Wisconsin is complete without reference to the “Blue Cross Mon-

ies”—truly, never have so few (dollars) been called upon to serve so many. The transfer of funds to our two medical schools, following the Blue Cross/Blue Shield conversion to a for-profit entity, will fund new community initiatives across the state but most dollars will be spent within the two schools. Even then, while the annual monies to be available are significant, they are small compared to the overall budget of each school; a realignment of the Schools, as a whole, will ultimately have a far greater impact than any direct expenditures of Blue Cross dollars. My experience with how both medical schools have been left largely unchanged by tens of millions of federal Area Health Education Center dollars is but one reason to be cautious. The public and community health oversight and advisory committees at each school have the levers to fundamentally transform both schools; whether they choose to do so, remains to be seen.

Health Plans—The medical imperative, “First, Do No Harm” must be respected at the regional level if it is to survive within local practices. We are beginning to see communities being undermined with the following situation: An individual must travel significant distances to find work and their employer offers only one health insurance option with a defined network that includes providers local to the place of employment but not the commuter’s home. Providers in the employee’s home area are not allowed to serve these individuals, even when they are willing to accept terms (financial and quality accountability) comparable to other contracted providers.

Section 609.22 of the Wisconsin Statutes states that “a defined network plan shall include a sufficient number, and sufficient types, of qualified providers... consistent with normal practices and standards in the geographic area.” State Administrative Code Ins 9.34 goes on to state that “Geographic availability shall reflect the usual medical travel times within the community.” The law and code is clear but the enforcement of fair guidelines is not.

Building and sustaining effective systems of care in local rural communities is a challenge on the best of days; it does little good to improve Medicare payments, modernize medical education, then look the other way when some health plans engage in selective contracting processes that have the effect of undermining local infrastructure by prohibiting patients

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 promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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from using local physicians. The irony of excluding physicians from defined networks in rural parts of the state is that even if the supply of physicians in the effected communities can be increased, local residents and employers will experience a decrease.

Community Systems—Those of us working at the local level have the greatest responsibility. Local health care “systems” are very complex entities, whether corporate or virtual, locally owned or part of regional corporations. But all are like large extended families which are capable of both fantastic teamwork and incredible dysfunction. As with most families the fights are usually over egos and money; healthy families and healthy systems know one member cannot be advantaged at the expense of another—it is the job of both physician and lay leadership to find the common ground.

There is much local physicians and communities can do; the following is taken from “Physician Recruitment and Retention,” *An Issue Paper Prepared by the National Rural Health Association -- November 1998*: “The retention of a physician in a community is dependent on the perception of that physician that his or her life needs have been satisfied. (Beyond financial remuneration), these perceived needs may be divided into professional fulfillment and lifestyle.”

Professional Fulfillment

- “Decrease professional isolation by supporting tele-informatics and outreach education programs of states and by the use of non-physician providers.
- Identify care needs at the community level. Use state and federal funds to assist rural hospitals and clinics where access to care would be threatened by hospital closure and physicians would be further deprived of opportunities to utilize their professional skills.
- Develop and use innovative delivery systems that emphasize coordination and cooperation among providers, institutions and communities.”

Lifestyle

- “Support initiatives to offer locum tenens to rural practitioners that would be available on a periodic

basis for purposes of continuing medical education or family vacations.

- Develop programs for support of the physician, spouse and children of the physician. This should include work and social opportunities for the spouse and family.
- Create innovative plans to share the workload through aggressive network building, partnering over distances, and sharing of resources.”

Summary—The Institute of Medicine of the National Academies in its November 2002 Report, *Fostering Rapid Advances in Health Care: Learning from System Demonstrations*, gives the best vision for American health care I have yet come across. “The health care system of the 21st century should maximize the health and functioning of both individual patients and communities. To accomplish this goal, the system should balance and integrate needs for personal health care with broader community-wide initiatives that target the entire population. The health care system must have well-defined processes for making the best use of limited resources.”

It is our job in Wisconsin to assure that we have “well-defined processes for making the best use of limited resources” for preparing and supporting physicians in rural communities.

Calling for Equality of Care Opportunities

From “Arguing for Rural Health in Medicare: A Progressive Rhetoric for Rural America,” by Thomas C. Ricketts, PhD, *The Journal of Rural Health*, 12/03:

“What can be the theme of a progressive rhetoric that argues for fair policies for rural America in the Medicare program?”

“A rhetoric of fairness for rural health systems can be made on the basis of efficiency. Rural health systems have been less costly than urban systems because of lower overall demand and use, not necessarily because of lower provider costs. In Congress, fairness in payment systems can be expressed as a reasonable

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"Rural America is Lake Wobegone: all the men are strong, women beautiful, children above average and medical providers make do with true grit and bake sales."

enlargement of the benefits of Medicare that compensates for the lower costs and use since it is likely that part of that is due to lower access to services. That enhanced access can be shown to be an effective way to ensure that all Medicare beneficiaries have equal access to the program while creating administrative efficiencies by providing the mechanism to support providers that have proven to draw less on the system than urban providers."

"The costs of care in rural places and for rural beneficiaries overall are the same or nearly the same, but rural health systems and rural Medicare beneficiaries manage to use fewer overall resources than urban systems. Why, then, cannot this efficiency be rewarded? The mechanisms are available in the form of tailored payment structures that single out critical access hospitals and rural health clinics. However, these should be normal expressions of a policy of equality rather than exceptions."

"Asking for recognition of the differences between caregiving in rural and urban places may seem like a call for distinction, even division, in a national system like Medicare. It is not; it is a call to provide equal consideration in the struggle to provide equal treatment for Medicare beneficiaries no matter where they live but adjusting to the realities of the systems of care that are available. The progressive rhetoric is in the emphasis for equality of care opportunities for

Medicare beneficiaries. The focus should be on a more progressive equality of opportunity to achieve the same outcomes no matter how differently the system is arrayed from place to place."

"The risk in making this form of argument is that policymakers often see it easier to try to equalize resource distribution, in this case setting equal rules for provider conduct, rather than seeking equal outcomes or opportunity for equal outcomes, accepting that there are reasonable differences in the caregiving structure that must be accommodated or adjusted for. Rural health systems must accept their limitations, but not the limitations that are imposed because they are forced by Medicare to act like urban health systems in ways that they cannot. Rural health systems have the same goals as urban systems: to provide the best care for Medicare beneficiaries as possible. That goal is achievable, but under different conditions. To make it clear just what those conditions entail requires an effective rhetoric that makes the positive case for unique systems and structures that can make for more uniform treatment and outcomes. The differences that accommodate rural needs lead us to greater fairness and justice."

Look for Savings Where Costs Greatest

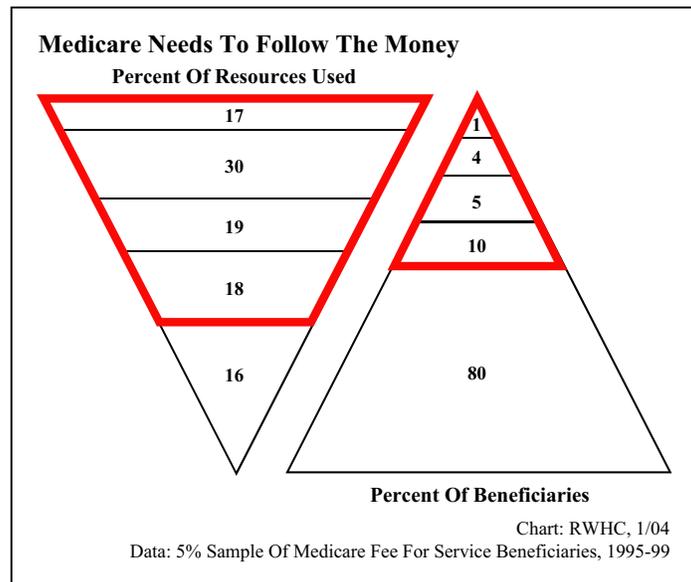
From "Reducing The Growth Of Medicare Spending: Geographic Versus Patient-Based Strategies," by Steven M. Lieberman, Julie Lee, Todd Anderson, and Dan L. Crippen, a *Health Affairs* Web Exclusive <www.healthaffairs.org>, 12/10/03:

High-Spending Medicare beneficiaries spending distributions. "Medicare spending is highly concentrated, with a small number of beneficiaries accounting for a large proportion of annual expenditures. During 1995–1999 the most costly 5 percent of beneficiaries in each year accounted for 47 percent of total Medicare spending, while the most costly 20 percent accounted for 84 percent of spending. By contrast, the least costly 40 percent of beneficiaries accounted for 1 percent of spending."

Description of the high spenders. "Who are these high-spending beneficiaries, and why do they have

such high spending? As their inpatient use indicates, they account for tens of thousands of Medicare dollars because they are more likely to be sick. The prevalence of serious chronic conditions is higher among high-spending beneficiaries than low-spending beneficiaries, for example. Almost 90 percent of beneficiaries in the top 5 percent of annual spending had at least one of the seven chronic conditions analyzed in this paper, compared with less than 30 percent of those in the bottom 40 percent.”

“An important consideration is whether high-spending beneficiaries are expensive because they are in the last year of life. If their high-spending designation reflected the typically high spending at the end of life, we would expect a sizable turnover in the composition of this group from one year to the next. In other words, those near death would receive a lot of expensive care at the end of life and would be included in the high-spending group that year but would die soon afterward. The dynamics of this process suggest that the next year a different group of beneficiaries at the end of life would constitute the high-spending beneficiaries. If true, the opportunity to intervene successfully with high-spending beneficiaries and reduce their Medicare spending would be limited.”



“Our data show that mortality is indeed higher in the top spending groups. During 1995–1999 a beneficiary ranked in the most expensive 5 percent was five times more likely to die than the average beneficiary. However, only one-fifth of the people in that group died by the end of that year; these decedents accounted for 11 percent of total Medicare spending in that year. Survivors accounted for 36 percent.”

“If a large fraction of total Medicare expenditures by high-spending beneficiaries is not incurred at the end of life, another important consideration is the nature of medical conditions responsible for high spending. In other words, do people who are not in their last year of life have high spending because they have an

acute and expensive episode in one year but subsequently recover, or do they have chronic and persistently expensive conditions year after year? In the first case we would expect a high turnover in the composition of the high-spending group, whereas in the second case we would not. More opportunities for successful intervention exist in this second group.”

Five-year spending patterns. “We have analyzed the persistence of Medicare spending over a five-year period (1995–1999). Among the beneficiaries enrolled in traditional fee-for-service (FFS) Medicare at the beginning of 1995, 27 percent accounted for 75 percent of five-year cumulative spending, whereas 73 percent accounted for 25 percent of cumulative spending. Of the 27 percent of beneficiaries accounting for the majority of cumulative spending, two-thirds (18 percent of all beneficiaries) were included in the top quartile of spenders in each year for at least two consecutive years. This group of persistently high-spending beneficiaries accounted for 57 percent of cumulative spending. The remaining third (9 percent of all beneficiaries) accounted for 18 percent of cumulative spending. Among persistently high-spending beneficiaries, 60 percent were alive at the end of five years, which suggests that the majority of spending associated with very costly beneficiaries is used by those who continue to live.”

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Disease management to reduce spending. “To lower Medicare spending, we can focus on this small group of very costly patients, at least in theory. Translating our insights on the patterns in health care spending into a workable program, however, is difficult. Disease management is one potential strategy that focuses on beneficiaries with high need for medical care. Disease management attempts to address two limitations in current medical practice. First, patients may lack coordinated care because they receive care from many different physicians or providers and might be limited in their ability to co-

ordinate care themselves. Second, as reported by the Institute of Medicine (IOM), there exists a large gap between evidence-based treatment guidelines (what medical research has shown to be the most effective protocols for treating specific diseases) and current practice. Disease management, by coordinating care across providers and encouraging adherence to evidence-based treatment guidelines, hopes to lower spending, improve the quality of care, and achieve better health outcomes.”

“Disease management is now offered as a health benefit by many large employers. Health plans either provide the service directly or subcontract with specialized disease management entities. Many population-based disease management companies have developed complex algorithms and use ‘data mining’ to identify potentially high-spending beneficiaries, such as those with specific chronic conditions. After identifying beneficiaries who are at greatest risk of having costly medical events, disease management companies offer an array of services intended to stabilize or improve the health of a beneficiary and avoid adverse medical events. The interventions might focus primarily on the beneficiary or his or her physician, seeking to educate, improve self-care, or increase adherence to evidence-based medicine. Proponents of disease management frequently claim savings, as well as improved quality or outcomes.”

“Disease management must overcome major challenges before its ability to lower Medicare spending can be determined. The effectiveness of the predictive modeling algorithms developed by disease management companies to identify high-spending beneficiaries remains unclear. Interventions developed for workers and their families in employer-sponsored insurance could be inappropriate or infeasible for elderly or disabled Medicare beneficiaries, especially given the prevalence of dementia and multiple chronic conditions. Our ongoing survey of the peer-reviewed literature suggests, at best, weak empirical evidence for long-term savings resulting from existing disease management programs.”

“Focusing on high-spending beneficiaries is conceptually straightforward: To save money, go where the money is. Success in this endeavor, however, depends on two propositions. First, we need to identify beneficiaries who are going to account for high

spending. And second, to realize savings, we need to intervene effectively before they become high spenders. Difficulty in identifying these beneficiaries and implementing cost-saving interventions remain the key challenges in the strategy targeting high-spending individuals.”

Federal Reserve Focus on Rural Health

From the Commentary “Bridging the Gap in Rural Healthcare,” by Nancy L. Novack in *The Main Street Economist*, a publication of the Federal Reserve Bank of Kansas City. The complete report is available at: <www.kc.frb.org>:

“Healthcare is a vital component of the rural economy. Not only is it an essential service to support a growing economy, but it also brings high-wage jobs to the communities it serves. In addition, a good healthcare system is an important indicator of an area’s quality of life. Healthcare, like education, is important to people and businesses when deciding where to locate. Nevertheless, the value of a good healthcare system is often overlooked when regions are crafting economic development plans and programs.”

“Providing access to healthcare has become extremely difficult for many rural areas. Such areas are often isolated and thinly populated, creating unique challenges for providing healthcare services in rural areas. Still, some innovative ways to enhance rural health have emerged in rural America. A common theme in these innovations is partnership—both geographically and across healthcare providers. State and federal agencies are recognizing differences in rural healthcare needs, and as a result, have made significant strides toward crafting policies aimed specifically at rural areas. No longer are rural towns viewed simply as “small cities” that can be served by policies created with metro areas in mind.”

“Rural regions cannot afford to overlook the role of healthcare in their quest for growing their region’s economy. Healthcare is an important component of the rural economy. Strong healthcare systems make for a healthier work force, provide jobs for high-skill workers, and enhance a community’s level of quality of life.”

“Studies have shown that 10 to 15 percent of workers in many rural counties are employed in the healthcare field. Typically, healthcare workers are some of the highest paid employees in rural areas. However, rural patients are increasingly traveling to metropolitan areas for their healthcare needs, thus exporting healthcare dollars out of their local community. As dollars drain out of rural areas, healthcare providers are taking new steps to boost confidence in their rural healthcare systems and create new efficiencies to make care more affordable.”

“Finally, healthcare is an important quality of life attribute that weighs heavily on the location decisions of businesses and workers. Business recruitment and retention are at the heart of many economic development efforts. Becoming a retirement destination has also become a rural development strategy for some areas. But communities that wish to cater to the wealthy generation of baby boomer retirees cannot ignore the need to provide quality healthcare. Some of the fastest growing rural communities in the last decade have been retirement destinations. And as the oldest of the baby boomers enter retirement, the demand for retirement communities swells.”

Raucous Times Favor Collaboration

From “Co-ops Help Keep the Lid on Hospital Costs,” *Cooperative Business Journal*, by M.P. Taylor, 12/03:

“ ‘Raucous times in any sector make collective models such as ours more desirable,’ added Tim Size of Rural Wisconsin Health Cooperative, a shared service provider. ‘The instability in the field now makes what we’ve been doing for 25 years make sense.’ ”

“Rising prices are particularly hard on small rural hospitals, which also face margin pressure from increased information technology needs, an aging workforce and a growing gap between real care costs and reimbursement through Medicare and Medicaid.”

“The just-enacted Medicare bill contains \$25 billion to reduce the inequities of a system that put

rural care facilities far behind their urban counterparts in terms of reimbursement. ‘It’s not a windfall; it replaces money that is less available from the private sector,’ said Size.”

“Rural hospitals have lost patients to urban hospitals that can afford to offer specialized services. ‘Even more troubling is the fact that they are traveling to these hospitals for services that are available locally,’ Size said.”

“RWHC was established in 1979 and today has 29 members. It is a local and national advocate for rural health and was one of the first organizations to speak out about rural-urban Medicare reimbursement inequities. The majority of its members are located in south-central and mid-state Wisconsin.”

“ ‘Being a cooperative is a way of thinking, it’s an attitude,’ said Size. ‘In the upper Midwest, it’s the way we demonstrate these values.’ ”

“Size said he sees the rising cost environment as ‘a time of opportunity rather than threat,’ because it fosters and forces innovation. ‘Our culture at RWHC is an emerging cycle of reinvention. We are here to serve our members and to make it easier for them to serve their communities, but how we do it has evolved and changed,’ he said.”

“Some services are dropped, others added and a number are used by a small subset of the rural member hospitals that act as ‘incubators’ for new ideas.”

RWHC Eye On Health



“Is it too late to discuss cooperation?”

Corporate Culture/Management Matters

From “100 Best Companies To Work For,” by Julia Boorstin in *FORTUNE*, 12/29/03:

“The 107-year-old family business is the very first manufacturer to make No. 1 on our list. But what’s really impressive is its secret recipe: a culture and management style as straightforward and likable as strawberry jam.”

“The best company to work for in America is headquartered in Orrville, Ohio (pop. 8,000), a quiet, tidy town 50 miles south of Cleveland. Employees don’t get any razzle-dazzle perks—no pet insurance, no subsidized feng-shui consulting, none of that. It’s a 107-year-old, family-controlled business that is run by two brothers who tend to quote the New Testament and Ben Franklin. It’s a throwback to a simpler time. If Norman Rockwell were to design a corporation, this would be it. In other words, J.M. Smucker & Co. couldn’t be trendier.”

“Smucker’s gimmick-free management starts with the co-CEOs, Tim and Richard Smucker. Tim and Richard are popular with their 2,930 employees—they’re affectionately known as the ‘boys’—which isn’t too surprising given that the company’s stock has had a total return of 100% over the past five years. The boys have made sure Smucker adheres to an extremely simple code of conduct set forth by their father and CEO No. 3, Paul Smucker: Listen with your full attention, look for the good in others, have a sense of humor, and say thank you for a job well done.”

Ag Health and Safety Forum, Feb 18th The Rural Wisconsin Health Cooperative and the Wisconsin Office of Rural Health are jointly sponsoring an Ag Health and Safety Forum on Wednesday, February 18, 2004, from 10:00 AM – 12:00 Noon in Sauk City. Dr. Steven R. Krikhorn, MD, MPH, Medical Director for the National Farm Medicine Center and Occupational Medicine at Marshfield Clinic, will discuss cardiovascular risks and the farm population. The purpose of the forum is to facilitate informal networking and best practices among health practitioners and administrative staff at organizations working with farmers and agricultural workers. This is not a policy forum. **For additional information and free registration, call 608-643-2343 or go to <<http://rwhc.com/AgForum.pdf>>.**

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