

Review & Commentary on Health Policy Issues from a Rural Perspective - May 1<sup>st</sup>, 1999

### Health Insurance Pools Make Good Sense

From *Toward a Private-Sector Model for a Small Employer Health Insurance Pool* by Chris Queram, CEO, the Employer Health Care Alliance Cooperative (The Alliance) (full text at <[www.alliancehealthcoop.com](http://www.alliancehealthcoop.com)>):

#### Introduction

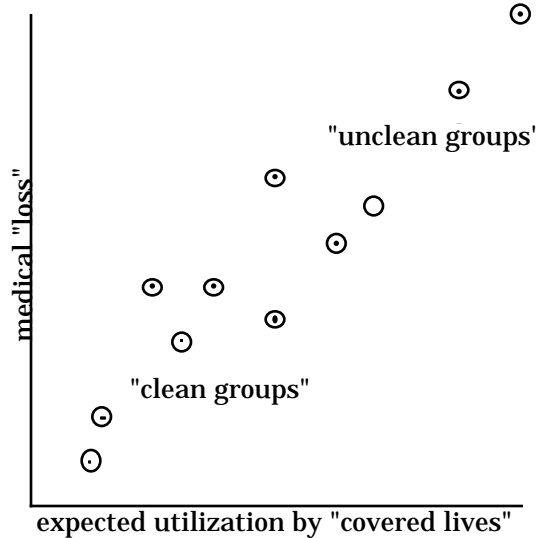
“Both the Thompson Administration and the Wisconsin Legislature are interested in responding to the growing difficulty experienced by small businesses in acquiring or maintaining affordable health insurance for their employees and dependents. While the approaches envisioned by the Governor and the Legislature vary in one fundamental respect (e.g., private- versus public-sector), both emphasize the concept of ‘pooled purchasing’, whereby small employers are brought together in a collective manner so as to increase bargaining power with plans and carriers.”

“The development and operation of a small employer health insurance purchasing pool requires certain ingredi-

ents to be successful over the long-run. The Alliance has acquired considerable experience in the small employer health insurance market.”

“Given this commitment and experience, The Alliance is in a position to help inform Wisconsin policymakers of the feasibility of alternative models and approaches to the small group market. This concept paper is intended to identify some of the factors that will limit or enhance the goal of improving the ability of small employers to access affordable health insurance.”

#### The World According to Health Insurers Truth Stranger than Fiction



graph: RWHC 4/99

#### Assumptions

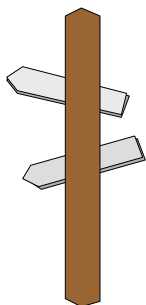
“The legislative and budgetary proposals introduced thus far offer similar yet distinctly different approaches to the small group market. One approach favors the private-sector (Gov. Thompson), while the other envisages a public-sector model (SB1). Neither proposal attempts to modify existing state insurance regulation so as to increase the potential for the pool to be successful. Thus, for this discussion piece, we assume the following:”

- “Whichever approach is adopted (private- or public-sector) will simply overlay the current regulatory scheme with no changes to existing rate bands, rating methodologies, or underwriting requirements.”

- “There will be no mandated participation by health plans or insurance carriers. In other words, the program will be completely voluntary.”

#### Program Limitations

“Given the foregoing assumptions, a small employer purchasing program will be necessarily limited in its scope, be it public or private. The major limitations would appear to include the following:”



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- “*Geographic Coverage*. With no requirement for plans to participate, it is quite probable that significant portions of the state will derive no benefit from either the public- or private-sector purchasing organization.”
- “*Plan Choice*. With voluntary participation, it will be difficult to generate multiple plan options in any market in the state.”
- “*Rate Affordability, Stability*. In the absence of significant rating reform, the ability to offer competitive premiums and predictable rate increases will depend largely on the ability of the group purchaser to successfully negotiate a favorable arrangement with willing health plan(s). Another factor influencing the long-term success of the program is the willingness of small employers to remain in the pool, even if there are more price-competitive plan options available outside the pool.”
- “*Single Life Groups*. Absent enabling legislation or market regulation, the ability to develop competitive options for sole proprietors may be limited. Again, the success will depend on the commitment and negotiating prowess of the purchaser organization.”

“Notwithstanding these limitations, it is possible that a well-conceived and executed voluntary private-sector can bring the benefits of pooled purchasing to selected markets in the state.”

#### *Keys for Successful Voluntary Initiatives*

- “The ‘demand side’ needs to be organized, committed, and knowledgeable.”
- “Governance and administration of a pooled purchasing model must be under the control of the buyer.”
- “A pooled purchasing model will require knowledgeable and dedicated staff, with some familiarity with and presence in the market(s) where the model operates.”
- “A small employer health insurance initiative needs the active support and participation of the agent community.”
- “Absent certain program features, a small employer health insurance initiative will have difficulty achieving differentiation in the market.”
- “Consequently, for a program to be successful, the pool will need to establish a partnership with health plan(s) willing to commit to program requirements more stringent than required by existing market regulations.”

#### *Desirable Market Requirement*

“As noted above, a major ‘Achilles heel’ under both the private- and public-sector models is the fact that participation by health plans/carriers is voluntary. This will limit the ability to attract plans/carriers on a broad geographic basis.”

“To rectify this, consideration should be given to enacting a requirement or incentive for health plans/carriers to participate in the pool. Approaches might include:”

- “*Requirement (‘Stick’)*. Require that any plan wishing to participate in the state employee program must offer a product in the small group pool. Or, that such a requirement will automatically take effect if the voluntary model does not meet specific success criteria within the first two years.”
- “*Incentive (‘Carrot’)*. Prohibit a plan/carrier from joining the pool for 3 years if it elects not to participate in the first offering. Or, create a financial incentive for participating plans—for example, a reduction in the HIRSP contribution required of the plan for each new group enrolled.”

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### Collaborating for Appropriate Antibiotics Use

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Dr. Ed Belongia, an epidemiologist at the Marshfield Clinic, presented to Rural Zones of Collaboration participants an overview of the Wisconsin Antibiotic Resistance Network (WARN). WARN is a statewide campaign supported by the federal Centers for Disease Control to reduce unnecessary antibiotic use and to prevent the spread of antibiotic resistant streptococcus pneumoniae. *Contact Bill McGill, bmcgill@rwhc.com or RWHC to learn how you might join this initiative.*

**The Rural Wisconsin Health Cooperative**, begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative 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.

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## Federal Dollars Not Dumping from Rural Sky

A well known speaker, while addressing a mid-April meeting of Wisconsin hospitals, joked about the Medicare money to be “dumped out of the sky” on rural hospitals due to the federal Balanced Budget Act of 1997 (BBA). Nothing could be further from the truth.

The reference probably related to the BBA increasing the minimum payment available to HMOs, IF they enroll rural Medicare beneficiaries, and IF the government increases are passed onto rural providers—two conditions not now seen and not expected in the foreseeable future. The reality is that the actual BBA Medicare cuts in traditional payments far outweigh the theoretical improvement of Medicare HMO payments.

The following is from *A Comprehensive Review of Hospital Finances in the Aftermath of the Balanced Budget Act of 1997* published by HCIA based on analysis by Ernst & Young, 3/99. Ernst & Young, LLP is one of the nation’s leading professional accounting, tax, and consulting firms. HCIA, Inc. maintains the health care industry’s largest health care data warehouse. It collects data from a variety of industry sources that include hospitals, managed care and insurance companies, federal and state governments, clinics, physicians’ offices, and patients. The complete report can be found at <[www2.hcia.com](http://www2.hcia.com)>:

**“Total hospital Medicare margins are expected to decline from 4.3 percent in FY 1997 to only 0.1 percent in FY 1999. These margins are projected to remain below 3 percent through FY 2002, the duration of the BBA payment reduction provisions.”**

“Total hospital margins are projected to decline 48 percent in just five years, from 6.9 percent in FY 1998 to 3.6 percent in FY 2002. While total hospital margins for all hospitals would have decreased even if the BBA had not been enacted, these margins are significantly smaller under the BBA and decrease at a much faster rate during the five-year period.”

**“Total hospital margins for small, rural hospitals are expected to fall from 4.2 percent in FY 1998 to negative 5.6 percent by FY 2002, a decline of 233 percent.”**

**“Findings on hospital Medicare inpatient margins are consistent with MedPAC.** While these find-

ings—which revealed that hospital Medicare inpatient margins decreased from 16.9 percent in FY 1997 to 16.5 percent in FY 1998—are consistent with those of the Medicare Payment Advisory Commission (MedPAC), they represent only a portion of the overall fiscal picture for hospitals.”

“Hospital outpatient margins are already negative 17 percent in FY 1998, and are projected to get substantially worse, dropping to negative 27.8 percent by FY 2002. The BBA has significantly reduced outpatient payments, payments that were already inadequate. This analysis modeled the impact of the elimination of the formula-driven overpayment (FDO), but not the impact of the outpatient prospective payment system (PPS). The PPS would reduce margins another 3.8 percent, according to HCFA’s impact analysis that was published in a September 1998 proposed rule. As outpatient revenues continue to increase as a portion of total hospital revenues, the impact of these negative margins will be even more injurious to hospitals.”

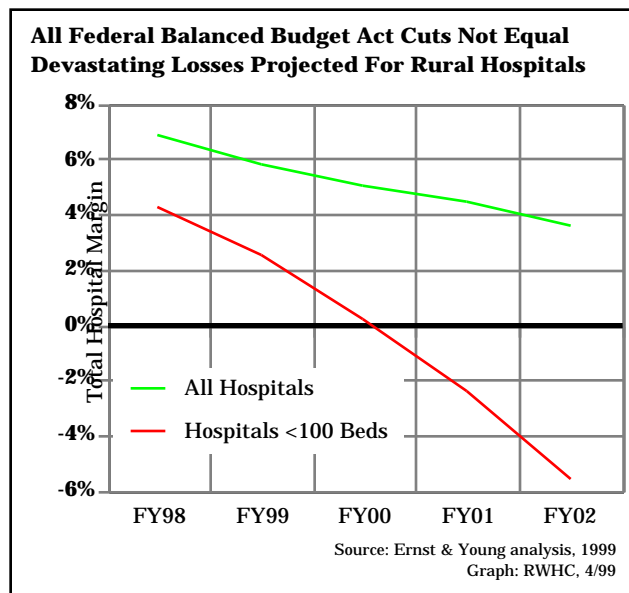
“The BBA’s transfer payment policy reduces hospital inpatient payments by approximately two and a half times more than original estimates. The transfer policy reduced inpatient payments between \$500 and \$800 million in FY 1998, and by approximately \$3 billion between FYs 1998 and 2002. The Congressional Budget Office (CBO) had estimated a \$1.3 billion five-year budget impact when the BBA was enacted in 1997.”

*“The magnitude of these reductions in margins and Medicare payments must be considered in light of two significant outcomes attributable largely to the BBA:”*

**“CBO projects Medicare spending will be \$191.5 billion lower than was anticipated when the BBA was enacted.** Recent CBO spending estimates for Medi-

care project total spending to be \$191.5 billion less than original estimates for FYs 1998 through 2002. CBO’s estimate of Medicare spending reductions at the time of BBA enactment was \$103 billion.”

“BBA cuts have shaken confidence in the health care industry and have led to numerous downgrades in bond ratings for community hospitals. Many analysts are attributing much of the precipitous drop in health care bond ratings to the impact of the BBA. Lowered bond ratings ultimately impair a hospital’s ability to access capital to finance technological and facility improvements which, in turn, negatively affect patient access to, and quality of, care.”



## A Rural Challenge to Enroll BadgerCare Kids

From *Why is Rural Important? Enrolling Rural Children in CHIP and Medicaid* by the federal Rural Work Group of the Interagency Task Force on Children's Health Insurance Outreach (the complete and detailed report with specific outreach recommendations is at <[www.nal.usda.gov/orhp/chip2.htm](http://www.nal.usda.gov/orhp/chip2.htm)>).

### *Rural Areas Are Not Just Small Urban Enclaves*

"As of February 9, 1999, the Health Care Financing Administration (HCFA) has approved the Children's Health Insurance Program (CHIP) plans of fifty states, territories, and the District of Columbia (known as BadgerCare in Wisconsin.) A year into the implementation of the largest increase in federal funding for children's health insurance since Congress passed Medicaid in 1965, attention has shifted from states rushing to pull plans together to states working to enroll children in their new programs."

"Some populations of American children are receiving greater attention in our outreach efforts due to higher rates of poverty and lower rates of insurance, specific barriers that make mainstream outreach efforts less effective, and disenfranchisement from the health care system in general. Rural and frontier populations are often left out of conversations of specially targeted populations. ...rural children are more likely to be uninsured than their urban counter part--21% of rural children are without insurance, versus 14% of children in urban areas."

"Rural areas are not just small urban enclaves in which mainstream outreach efforts can be downsized and effectively implemented without translation. The rural context, while containing some of the same elements as the urban context, is different and warrants focused attention. While rural areas are extremely diverse, there are some generalizations that can be made about rural demographics and infrastructure that help to place outreach in rural areas in the appropriate context."

"Rural areas have higher rates of poverty than urban areas. In 1997, non-metro counties had a 15.9% poverty rate compared to 12.6% for metro counties. This higher rate of poverty can partially be attributed to a higher reliance on minimum wage jobs and service sector employment in rural areas."

"While rural economies are no longer exclusively dependent on farming, rural areas still have a higher per-

centage of small business economies than urban areas. Low wages and smaller business size in rural areas also mean that rural residents have lower rates of employer sponsored health insurance coverage. 51.7% of rural employees are covered by employer health plans compared to 60.4% coverage in urban areas. Lower rates of employee sponsored insurance contributes greatly to the lower rate of insurance for rural children. Therefore, partnering with small rural businesses may prove an effective outreach strategy."

"The characteristics of rural communities also may suggest subtle differences in outreach strategies. For example, rural welfare recipients are more likely to be employed and married than urban recipients. Rural communities are smaller communities in which residents are more familiar with each other than in urban areas. This familiarity is often coupled with a distrust of outsiders and newcomers. Many rural communities also have strong religious values and have strong connections with their local churches. Rural areas also have a large elderly population. These respected elders provide much of the childcare in rural areas, and may serve as a special target for rural outreach."

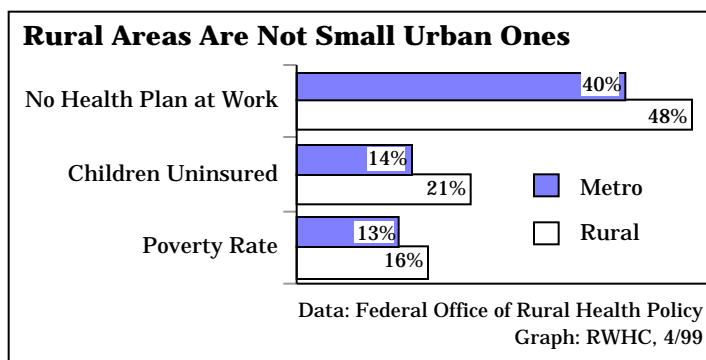
### *Enrolling Rural Children for Health Insurance*

"It is this rural context that outreach efforts need to focus on reaching rural children. A United States General Accounting Office report in March 1998 discussed general reasons why children may not be enrolled in Medicaid or CHIP. The working poor may not realize they are eligible. The delinking of Medicaid and cash assistance also has created confusion for families and service providers. Outreach efforts will also have to deal with cultural misunderstanding, language barriers, and the negative perception of dependency. Efforts will also have to be made to simplify and explain the cumbersome enrollment process and health system."

"These factors, compounded by sparse rural populations and less health infrastructure, suggest that **outreach efforts in rural areas may require more effort, more time, and a higher initial investment.** While it is too early in the CHIP implementation process for a complete evaluation of rural outreach efforts, there are lessons that can be learned from

'rural' states that have had some success in reaching children. We also can learn from efforts in Medicaid outreach that preceded CHIP. There are also lessons from CHIP outreach success stories in rural communities."

"In Balsam Lake, Wisconsin, ABC for Health Inc. developed an outreach model that has been successful in



increasing Medicaid enrollment. Since 1988, the project has used family health benefit counselors at local health departments to assist clients in enrolling in public assistance on a family-by-family basis. In 1998, the project began to focus on children's health insurance programs, and has since expanded to 17 counties in northwestern Wisconsin. The counties share information on available programs, rules, and regulations. These counselors do not just enroll children; they also review applications, assist clients when they have been denied coverage, and provide guidance for hearings and appeals. Public health nurses refer families to the counselors, and a small team of public interest lawyers and law students provides technical assistance to the counselors and families."

"The program's success is linked to the dedication of resources by health clinics and health departments. Health clinics have found that the program is only beneficial when they can dedicate enough staff support to the effort. After eighteen months, one clinic found a 46% increase in third-party payment. Project Director Michael Rust says 'the clinic administrators told us that we gave them a new outlook on working with the community.' They said 'We'll do anything we can because we discovered it's to the family's benefit and it's to the clinic's financial benefit.'"

"Rural communities often have few choices when it comes to primary care providers. For the enrollment of children in CHIP and Medicaid to lead to improved health outcomes, the health professionals that currently reside in rural areas will need to participate. With many states turning to managed care as a way of increasing eligibility, it is important that these managed care programs include rural providers. It will not help a child to be insured if the only doctor that can treat him or her is 50 miles away."

"Rural families will also need help accessing the health care system. Basic assumptions made by the health care system may not be true in some rural areas. For example, some poor rural families do not have phones. Transportation problems in rural areas are severe because of a lack of public transportation and farther distances to travel to get to a medical facility. Training outreach workers in rural communities that can help families enroll children in programs, and then work with families to help them access the system, can help to alleviate some of these problems."

"Although a strong case can be made for the need to focus on rural communities, the rural context is not completely unique and distinct from the urban setting. To the contrary, the similarities between the two settings are striking and a lot will be gained by sharing experiences between both settings. Rural areas and urban areas face many of the same problems, but many times rural communities experience these problems in different degrees or with a different spin."

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## How Many Ways Can You Say Unsustainable?

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From "Health Care: The Cold Truth" by David S. Broder in *The Washington Post*, 4/7/99:

"In the headline of an article in the April issue of the monthly magazine of the National Conference of State Legislatures: 'Government Does, Indeed, Ration Health Care.' The author is a man known for disgorging uncomfortable truths, former Colorado governor Richard Lamm. Speaking of American medicine, Lamm says, 'We are inventing the unaffordable and spending the unsustainable. We need to focus limited resources where they will buy the most health for society.'"

"He cites some of the evidence. In this age of medical breakthroughs, health care has overtaken housing as the most expensive item in the family budget -- and health care spending is growing faster than anything else in state and federal budgets. The annual medical bill represents one-seventh of the nation's economy."

"And yet, the United States has by far the largest share of uninsured citizens of any advanced nation, with 43 million having no coverage now. Of 29 industrial countries, we rank 21<sup>st</sup> in infant mortality, 17<sup>th</sup> in life expectancy for women and 21<sup>st</sup> for men. Lamm is far from alone in arguing that the current health care system is unsustainable. Health and Human Services Secretary Donna Shalala says the same thing. So do many other experts."

"The question, as Lamm writes, is not if we ration -- but how. So far, we have chosen to ration by leaving one-sixth of our population uninsured and, increasingly, by trying to let medical organizations 'manage' the health care of those with insurance. Since the failure of the Clinton administration's bill for universal health insurance in 1994, efforts to expand coverage have been sporadic, and the number of uninsured has grown by roughly a million a year."

"What is almost as worrisome is the fact that the major health care reforms being considered in Washington ignore the fact that society must make hard choices about what it can afford -- and how those dollars can best be used. Indeed, they threaten to exacerbate the problem by promising that the privileged will be even better protected."

"The individual stories are so compelling that the social costs are ignored. If every patient is guaranteed every service that could provide even a marginal benefit in someone's judgment, then what will the economic consequences be? The answer, Lamm writes, is that 'the dollars we spend on marginal and futile care are no longer available to spend on needed care for someone else in the system or some other equally important social need. The health care system can no more afford to do everything 'beneficial' for every patient than the edu-

cation system can do everything 'beneficial' for every student... or the police department for every citizen... We are funding health care by an unsustainable yardstick.' "

"Writing in this vein sounds coldhearted. But the real cruelty is ignoring these truths. Until we insist that all Americans of all ages -- including the retired -- contribute to the costs of their health care as far as they are able, until we acknowledge that additional benefits for those with insurance are less vital than providing access to basic care for the uninsured, the political finagling over health care in Washington is likely to do more harm than good."

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## The Changing Face of Medicare

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From *Medicare+Choice--Questions and Answers* from Wisconsin's Office of the Commissioner of Insurance (the full text is available by calling 1-800-236-8517 or <[http://badger.state.wi.us/agencies/oci/pub\\_list/](http://badger.state.wi.us/agencies/oci/pub_list/)>):

"This brochure explains new options available to persons age 65 and over, and some disabled individuals under age 65, who are looking for information about the Medicare+Choice program. Medicare+Choice expands the way in which your health care is delivered. It may or may not provide additional benefits to enrollees. It is also important to remember that while Medicare+Choice gives you additional options; there is no requirement that you choose a Medicare+Choice plan. NOTE: If you are happy with your current coverage, you do not have to change. Most of the options created by Medicare+Choice are not yet available in Wisconsin. (Editors Note: In good part, these options are not likely to be available until Wisconsin is able to organize itself with other similarly disadvantaged states to correct historic federal payment inequities.)"

### *What are the new options under Medicare+Choice?*

"Each company offering Medicare+Choice health plans must be licensed as an insurance plan in Wisconsin before Medicare will enter into an arrangement to purchase coverage for you. Among the Medicare+Choice choices that you are likely to see offered are:"

**"Health Maintenance Organization (HMO):** A type of health plan with a defined list of providers, often referred to as a network, that enrollees must use. HMOs generally have more restrictions on the providers you may use than any other type of health plan you can enroll in, although they often provide benefits, such as preventive care, that are not available from other types of health plans. Normally, an HMO will only make referrals to non-network providers in unusual situations. The HMO may also require that you obtain a referral from your primary provider before seeing a specialist. Other than in an emergency situation, an HMO will

likely not pay for services you obtain from a provider who is not part of the HMO's network. Before you enroll in an HMO, you should carefully review the list of providers that is available through the HMO."

**"Point of Service Plan (POS):** A type of health plan with a network of providers that also permits enrollees to use non-network providers, usually at some additional cost to the enrollee. The plan may also have requirements that you obtain a referral from your primary provider before the plan will agree to pay for out-of-network care. Many HMOs are starting to offer POS options with their HMO plans. This option is generally more expensive than a regular HMO, but allows enrollees more choices of providers."

**"Preferred Provider Plan (PPP):** A type of health plan that also uses a network of providers, but permits enrollees to go outside the network. Generally if you obtain services from a network provider, your costs are lower. PPPs are the least restrictive form of coordinated care."

*Other Medicare+Choice options you may hear about are:*

**"Medical Savings Account (MSA):** A high deductible insurance health policy that is carried along with a tax-exempt trust fund to pay for expenses to meet the deductible. The deductible may be as high as \$6,000 annually."

**"Medicare Private Fee for Service:** A type of health plan that allows you to purchase private health insurance. The plan makes arrangements for your care with providers and may charge you, through premiums, additional out-of-pocket expenses, or both, for any cost that exceeds what regular Medicare would pay."

**"Religious Fraternal Benefit Society (RFB):** A type of health plan sponsored by a religious fraternal benefit society that is recognized by the IRS. Generally, you must belong to a specific religion to join this type of health plan."

**"Provider Sponsored Organization (PSO):** An entity organized by a group of providers that provides a substantial portion of care to Medicare enrollees and assumes financial risk for the care."

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## Shortage of Rural Physicians Is Solvable

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From "Physician Education And Rural Location: A Critical Review" by: John P. Geyman, M.D. et al; WAMI Rural Health Research Center, 2/99 (contact WAMI at [wamirhrc@fammed.washington.edu](mailto:wamirhrc@fammed.washington.edu)):

"The shortage of physicians in rural America is a long-standing problem that has persisted as physicians continue to preferentially settle in metropolitan, suburban,

and other non-rural areas. The last two decades have seen a variety of strategies introduced by federal and state governments and by medical education programs in an effort to ameliorate this problem and promote the choice of rural practice by graduates.”

“This critical review was undertaken to assess what has been learned from the various initiatives taken by predoctoral and graduate medical education programs in the United States to encourage preparation for, and choice of, rural medical practice.”

“Among the many issues involved in efforts to increase the physician supply in rural underserved areas, these stand out as especially important:

- More physicians need to be trained, recruited to, and retained in rural practice.
- Selection of rurally-oriented students is no longer a mystery, but remains an issue.
- Residency training needs to be carefully structured to prepare graduates for rural practice, including real-world rural experience.
- Despite the demonstrated success of rural training models, accreditation barriers persist.
- Rural training and practice sites no longer need to be isolated.

- Rural health care services are still under reimbursed, threatening the viability of rural training programs as well as physician recruitment and retention in rural practice.
- Many fiscal barriers to the production and retention of rural physicians are within the purview of federal and state governments, but a coherent strategic approach has not been taken.”

“As the 1998 Council on Graduate Medical Education’s Tenth Report (COGME) concludes, the most pressing challenge in geographic maldistribution of rural physicians is in ‘small rural’ areas (less than 10,000 people, not adjacent to metropolitan areas). The predominant need here is for family physicians.”

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### Not Laughing--Right Frontal Lobe Challenged?

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From “Understanding How Humor Works Far From A No-Brainer” by Usha Lee McFarling, Knight Ridder Newspapers, 4/1/99:

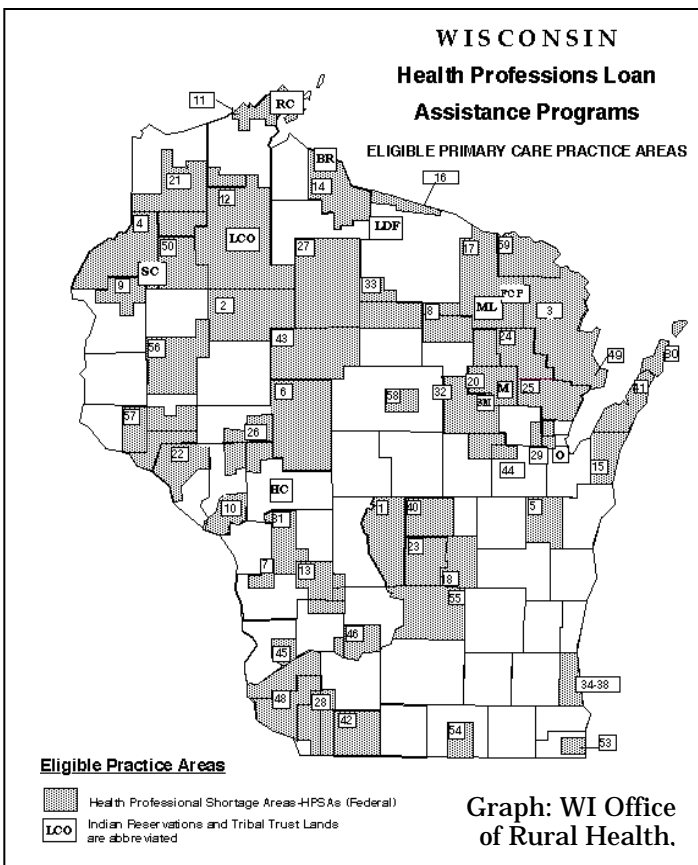
“Amid all the marvelous things we humans can do with our big brains, none is quite so mysterious as our ability to enjoy a good joke. That’s largely because few scientists have bothered to investigate how humor works.”

“Now, though, two Toronto psychologists say they’ve pinpointed the part of our brain largely responsible for our ability to understand a punch line and turn it into a hearty laugh. The team conducted its search for the seat of humor by observing how 31 men and women, some with minor brain damage and some with healthy brains, responded to jokes. Brain damage in general was not a killjoy.”

“But people with damage in one specific area -- the right frontal lobe -- had trouble understanding jokes that required making verbal connections and ‘had absolutely no smile or laugh’ even if they did understand the jokes, said the study’s lead author, psychologist Prathiba Shammi.”

“What role might the frontal lobes play in humor? Well, if you dissect a joke -- as these scientists were happy to do -- you’ll find it has many sophisticated components. It involves taking in linguistic information, sifting through memories, making comparisons and solving problems.”

“Once that heavy lifting is done, there’s still the task of connecting the intellectual knowledge with our emotions so that mere words can set off a smile, a giggle or a guffaw. The frontal lobes fit the task perfectly. ‘What little is known of them suggests they are a site where information from throughout the brain and emotional



responses are integrated. This area of the brain can make lots of those connections,' said Stuss."

"While the frontal lobes may play a pivotal role in processing jokes, the authors cautioned against oversimplifying either the brain or humor by concluding that the brain has a single humor center. Other workers in the fledgling field of humor science agreed. 'It takes a whole brain to appreciate humor', said Peter Derks, a psychologist at the College of William and Mary."

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## Transforming How We See Transforming

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From "Fear Of Transformation" in the *The Essene Book of Days* by Edmond B. Szekely:

"Sometimes I feel that my life is a series of trapeze swings. I'm either hanging on to a trapeze bar swinging along or, for a few moments in my life, I'm hurtling across space in between trapeze bars."

"I have noticed that, in our culture, this transition zone is looked upon as a 'no-thing,' a no-place between places. Sure the old trapeze-bar was real, and that new one coming towards me, I hope that's real too. But the void in between? That's just a scary, confusing, disorienting 'nowhere' that must be gotten through as fast and as unconsciously as possible. What a waste. I have a sneaking suspicion that the transition zone is the only real thing, and the bars are illusions we dream up to avoid the void, where the real change, the real growth occurs for us."

"Whether or not my hunch is true, it remains that the transition zones in our lives are incredibly rich places. They should be honored, even savored. Yes, with all the pain and fear and feelings of being out-of-control that can (but not necessarily) accompany transitions, they are still the most alive, most growth-filled, passionate, expansive moments in our lives."

"And so, transformation of fear may have nothing to do with making fear go away. But rather with giving ourselves permission to 'hang-out' in the transition between trapeze bars. Transforming our need to grab that new bar, any bar, is allowing ourselves to dwell in the only place where change really happens. It can be terrifying. It can also be enlightening, in the true sense of the word. Hurtling through the void, we just may learn how to fly."

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## WI PT of the Year Serves Rural & Urban Alike

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The Wisconsin Physical Therapy Association has honored Julie Swedarsky at the UW-Madison as Physical Therapist of the Year. RWHC focus is on the care provided in rural communities but this year's award serves as a reminder of the importance of the care provided to rural patients in large urban hospitals. Julie was nominated by a patient from rural Rothschild after an extended hospitalization for a rare chronic illness.

"She was my physical therapist, at first the bane of my existence, then my rescuer and my friend. The exercises were so hard--my mind was willing but my body wanted nothing to do with it... Often, I'd close my eyes and try to pretend I was somewhere else. That's usually when I'd hear a woman's booming voice coming down the hall. 'Where is she?' she'd call loudly, knowing full-well I was where she always found me--laying in the damn bed--little more than dead weight."

"About her help with my physical recovery, one could say she was just doing her job, but I don't agree. She was remarkable--just the right combination of the tough love I needed. She always encouraged me to do more when I thought I couldn't. As important, she reveled in my every success and was sincerely disappointed when setbacks occurred. She was always energetic, always empathetic, and always demanded the most of me--but never gave less than that herself."

### RWHC - Eye On Health

Each Year, 3 of 4  
kids eligible for  
Medicaid don't get  
any dental care.



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When their teeth go--let them eat cake.