

Review & Commentary on Health Policy Issues for a Rural Perspective – January 1, 2020

“Structural Urbanism” and Rural Health

From the Overview “Structural Urbanism Contributes to Poorer Health Outcomes for Rural America” by Janice Probst, Jan Marie Eberth, and Elizabeth Crouch in *Health Affairs*, December, 2019:

“Rural populations disproportionately suffer from adverse health outcomes, including poorer health and higher age-adjusted mortality. We argue that these disparities are due in part to declining health care provider availability and accessibility in rural communities. Rural challenges are exacerbated by ‘structural urbanism’—elements of the current public health and health care systems that disadvantage rural communities. We suggest that biases in current models of health care funding, which treat health care as a service for an individual rather than as infrastructure for a population, are innately biased in favor of large populations. Until this bias is recognized, the development of viable models for care across the rural-urban continuum cannot move forward.”

“The current interest in rural America has multiple roots. The 2016 US presidential election was widely perceived to be influenced by rural voter dissatisfaction, which drew attention to rural. Studies published in the mid-2010s found that rural rates of suicide and overdose mortality among middle-aged non-Hispanic white adults, termed ‘deaths of despair,’ had increased

to meet and exceed those rates in urban areas. A widely read memoir published in 2016 purported to illustrate the social, cultural, and economic milieu of rural Appalachia. In 2017 the Centers for Disease Control and Prevention issued multiple reports that examined rural health and health-related behaviors, including suicide, seat belt use, smoking, and receipt of preventive health services. Losses in rural health infrastructure were discussed in leading general-interest and medical periodicals in 2018. **Across the political spectrum, rural health is anticipated to remain a priority issue.”**

“For this revival of interest in rural issues to yield meaningful change, thoughtful examination of the health disparities experienced by rural populations and potential policy solutions to these disparities is essential. To open the discussion, we suggest that ongoing rural challenges are exacerbated by ‘structural urbanism’—elements of the current public health and health care systems that disadvantage rural communities as they seek to enhance, maintain, or rebuild health care infrastructure to support population health.”

RWHC Eye On Health



“Looking at rural health through an urban lens makes as much sense as Amazon selling just one shoe size.”

“We define structural urbanism in health care as a bias toward large population centers, stemming from three factors: a market orientation in health care, which necessitates a critical mass of paying customers to make services viable; a public health focus on changing outcomes at the population level, which differentially allocates funding toward large population centers; and the innate inefficiencies of low-population and remote

settings, in which even equal funding can never translate into equitable funding. We suggest that a new discussion of rural health care is needed, one in which health care is defined as a public good rather than a product, with ensuing implications for funding.”

“Structural urbanism has deep roots and may be impossible to eliminate completely. However, one way to begin is by assigning value to rural communities and the people who live there. Given greater flexibility, as well as better funding models, rural communities would be able to invent new types of facilities for size-appropriate rural health care hubs. As these new models are developed, the traditional use of the term scalability should be turned on its head. Instead of asking, ‘Can this model handle more?,’ communities could raise the opposite question: ‘Which system elements can be scaled down while still providing safe and effective care and improving population health?’ ”

“At a national level, the health of rural residents can be monitored responsibly. More research into lagged effects of changes in local health care systems on health outcomes would then be possible to document which communities are most at risk when service levels fall below a necessary minimum. Research and demonstration projects can be used to define the service mix needed to maintain the health of specific types of rural communities. Conceptualizing rural health care as infrastructure, similar to electricity or telecommunications, may provide a path for permanent funding, through whatever mechanisms can be designed.”

Say No to the Wrong Surprise Billing Fix

From “Protect Rural Health from the Wrong Surprise Billing Fix” by Tim Size, RWHC Executive Director, in the *Capital Times*, 11/27/19:

“Preserving access to quality health care in rural parts of Wisconsin is becoming a bigger and bigger chal-



lenge. Reimbursement rates from Medicaid and Medicare that are too often below the cost of the service, provider shortages, dairy industry struggles and an aging population are some of the factors conspiring to present existential challenges to rural health care providers.”

“In fact, according to the University of North Carolina Center for Health Services Research, 119 rural hospitals have closed across the county since 2010. Even more disturbing, a 2016 report for the National Rural

Health Association found that 700 rural hospitals were at risk of closing.”

“Despite the already fragile nature of rural health care, providers are facing a new threat in the form of legislation being considered in Congress right now.”

“As you might have heard, policy makers from the president to members of Congress on both sides of the aisle have grown rightfully concerned about ‘surprise medical bills.’ Surprise bills happen when a patient receives needed medical treatment only later to find out the provider is not covered by his or her insurance. The result can sometimes be a very large medical bill that is sent to the patient.”

Eye On Health is the monthly newsletter of the Rural Wisconsin Health Cooperative. Begun in 1979, RWHC has as its **Mission** that rural Wisconsin communities will be the healthiest in America. Our **Vision** is that... RWHC is a strong and innovative cooperative of diversified rural hospitals... it is the “rural advocate of choice” for its Members... it develops and manages a variety of products and services... it assists Members to offer high quality, cost-effective healthcare... assists Members in partnerships to make their communities healthier... generates additional revenue by services to non-Members... ongoing use of strategic alliances in pursuit of its Vision. Tim Size <timsiz@rwhc.com>, Editor, 880 Independence Lane, Sauk City, WI 53583

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“There is general consensus by all stakeholders that patients should be taken out of the middle of these kinds of disputes which are really between insurance companies and health care providers. However, unfortunately, some are pushing a plan that would greatly advantage insurance companies at the expense of health care providers.”

“Under this scheme, ‘benchmark’ rates would be established that providers would be required to accept—regardless of what the actual services cost—in any case when a patient receives an unexpected out-of-network bill. The benchmark rate would be based on median in-network rates paid by insurers.”

“By basing reimbursement rates for out-of-network care on the rates for in-network care, insurers would have little to no incentive to contract on equitable terms with providers – especially in rural areas – leading to even smaller provider networks. At the same time, many rural patients would find themselves paying higher co-payments to access local providers or weakening the rural safety net by out-migrating needed care.”

“If there are fewer doctors, clinics and hospitals available in rural areas, patients will struggle with access to care. Longer wait times for appointments, longer travel distances and unmet health needs are all consequences of losing rural providers.”

“The good news is there are alternatives to benchmark rate-setting that are fair to both insurance companies and providers. No one disputes the need to address surprise medical bills. However, the solution should not be an insurance company giveaway that will lead to driving down already low reimbursements rates for rural providers.”

“Geography should not be a factor in access to quality health care. Congress should keep that in mind as it works on surprise medical billing.”

Meaningful Rural/Urban Conversations

From “How to Understand Rural/Urban Differences, Both Real and Imagined” by Tim Size, RWHC Executive Director in the *Daily Yonder*, 11/26:

“George Washington warned us all too well of the dangers of extreme partisanship, stating in his Farewell Address, ‘It agitates the community with ill-founded jealousies and ... foment occasional riot and insurrection.’ Today most of us are seeing, if not experiencing, the contempt that many liberals hold for conservatives, and conservatives for liberals.”

“Since the Presidential election, there has also been a lot of discussion about the rural/urban ‘divide.’ While it is fair to say that rural communities tend to be more conservative than most urban communities, many rural communities are pretty ‘purple,’ with a healthy mix of both parties.”

“If we want to better understand and bridge the rural/urban ‘divide’ we need to dig deeper than just repeating stereotypes about conservatives and liberals.”

“To that end, a couple weeks ago, I walked around RWHC’s Office & Training Center in Sauk City informally asking what they heard from urban individuals and organizations that seemed different from what they hear in rural Wisconsin; what expressions or ideas that just didn’t ring ‘true’?”

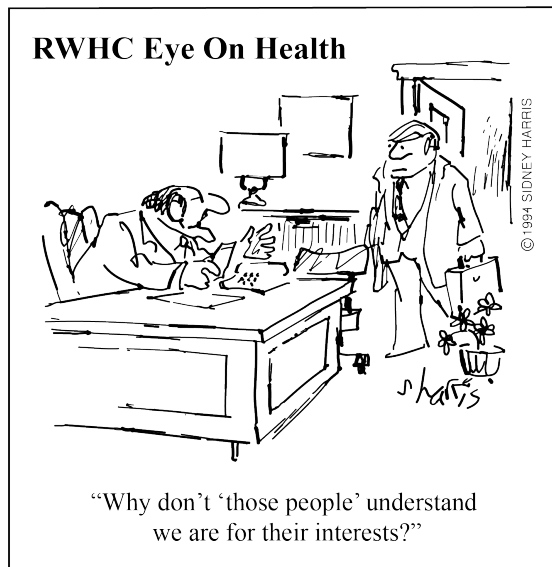
“Below are a few examples of what I heard; they are not shared as some set of absolute truths; they

are intended to be seen as opportunities to start conversations, not end them:

‘Urban’ Talk May Tend Towards vs. ‘Rural’ Talk May Tend Towards:

1. My Values Don’t Differ from Rural vs. My Values Differ from Urban

RWHC Eye On Health



2. With Healthcare, Bigger is Better vs. With Healthcare, Local is Better
3. Regulated Interdependence vs. Voluntary Interdependence
4. Specialists are More Useful vs. Generalists are More Useful
5. Appreciate Government Support vs. Feel Get Unfair Share Government \$
6. Progressive Describes Progress vs. 'Progressive' May Not Be Progress
7. Separation Church and State Under Siege vs. Christianity Under Siege
8. Equity is About Outcomes vs. Fairness is About the Process
9. Equity Focus on Racial Disparities vs. Fairness Focus on Economic Disparities

10. Happy Holidays vs. Merry Christmas”

“I am grateful to be part of Wisconsin Partners (a new association of statewide associations and local regional community building initiatives.) Our focus is on doing real work but understanding that it must start by taking the time to build relationships. With help from Wisconsin Partners colleagues, I have learned that taking the time to better understand each other as individuals is a great way to ‘finding the common ground’ to accomplish real work. Info at:

www.wisconsinpartners.org

“Yaffa Fredrick, in her essay ‘Welcome to the Fractured States of America,’ quotes the American filmmaker Ken Burns: ‘We all have stories. And sometimes they lead us back to emotions and feelings we have in common.’ She goes on to say ‘That may require breaking out of our red and blue silos and actually grabbing beers with someone of a different political persuasion.’

“With or without beer (or cheese curds), we can find that rural and urban have more in common if we take the time to discuss our real differences and understand our imagined ones.”

Forty-one pairs of “Conversation Starters re Urban-Rural Language Differences and Other Stumbling Blocks to Understanding Our Working Together” are available at: <https://bit.ly/2QpT2q1>

Options to Closed J-1 Visa Waiver Program

From “Conrad J-1 Waiver Program for Wisconsin Closed—Other Options” by: Doris E. Brosnan, Chair of Immigration Law Section, von Briesen & Roper, S.C.

“On October 17, 2019, the Wisconsin Department of Health Services (DHS) announced that all 30 of the available Conrad J-1 waivers for Wisconsin had been claimed. The program, which provides for a waiver of the 2-year home residency requirement for foreign medical residents if they provide primary or mental health care shortage areas in Wisconsin, is no longer accepting any further applications. Until next year’s Conrad program opens up, there are some options available for rural health systems wanting to hire foreign medical graduates who are subject to the 2-year home residency requirement.”

Canadians—“Although Canadian physicians who complete fellowships and residencies in the U.S. are often technically subject to the 2-year home residency requirement, there is a work-around that can effectively allow them to stay in the U.S. in H-1B status. (Canadian physicians are not eligible for TN status unless they are accepting research or teaching positions). Because Canadians do not need visa stamps in their passports, employers who wish to employ Cana-



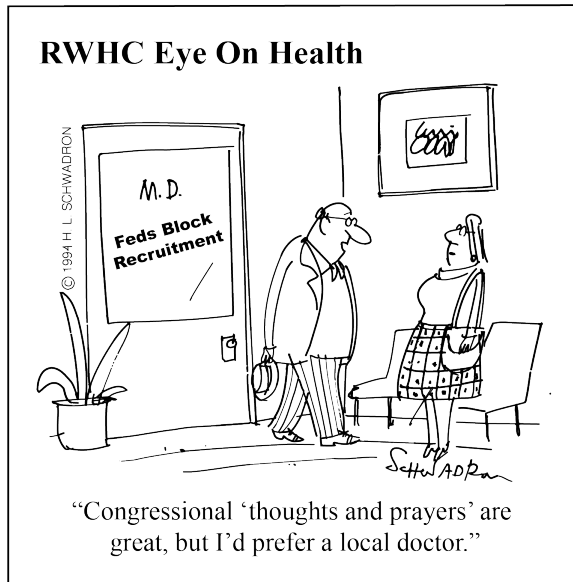
Rural Health Foundation

As the National Rural Health Association’s Rural Health Leadership and Education Foundation approaches our 10th anniversary, we are launching a 3-year pledge drive to further develop rural health community leadership.

Donations will add to our permanent endowment to support programs that identify emerging leaders from and for rural communities and provide them with training and resources.

Please contact timsze@rwhc.com for assistance in making a three-year pledge or donate online at: <https://bit.ly/2pQEDGh>

dian physicians subject to the 2-year home residency requirement may request an approval of an I-129 petition for a Canadian physician. Although this strategy allows the physician to stay in the U.S. in H-1B status, the physician would not be able to pursue a green card. Therefore, employers who pursue this strategy would need to apply for the Conrad J-1 waiver program the following year, if possible, in order to waive that home residency requirement. Employers should remember the normal limits of the H-1B visa program—unless classified as exempt from the H-1B cap, the employer will need to enter the H-1B lottery for FY 2020 on April 1, 2020, to win one of the 85,000 H visas available year, for an October 1st start date.”



“One final option is to have the candidate locate and work another 1-year fellowship until the Conrad program opens up again next year in Wisconsin. All of these options require the aid of an immigration attorney experienced in obtaining waivers of the 2-year home residency requirement.”

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Rural Can Lead with a Culture of Health

Persecution or Hardship Waivers—“The Department of State (DOS) may grant waivers of the 2-year home residency requirement in certain cases of persecution or hardship. If the J-1 visa holder would be persecuted due to race, religion, or political opinion if they return to the home country, the DOS may grant a waiver. With a hardship waiver, the DOS may grant a waiver if the physician can demonstrate that extreme hardship conditions that would need to be endured should a foreigner be required to adhere to the two-year physical presence requirement.”

No Objection Letter—“Foreign nationals subject to the 2-year home residency requirement have the ability to request a ‘No Objection Statement’ from their home government. Under this process, the physician would submit an application to the DOS, which then requests the No Objection Statement from the applicant’s home country embassy in Washington, D.C. The employer and physician should familiarize themselves with the specific home country’s No Objection Statement process, all of which are slightly different. For example, India requires that the applicant obtain multiple permissions from the applicant’s local, state and central government in India before applying to the Indian consulate in the U.S.”

From “A Culture of Health—Rural Prize Winners Reshape How Communities Look at Health, Three of the five winners of this year’s Culture of Health Prize are small towns or rural areas,” *Daily Yonder*, 12/3/19:

“When officials in Lake County saw the results of the 2010 Healthy Kids Colorado survey, they knew they had to do something.”

“Substance abuse and school absences were up. Academic performance was down.”

“In response, leaders organized a community-wide effort to improve the lives of students in the rural Colorado county, situated along the crest of the Rocky Mountains.”

“The effort has started to pay off, said Brayhan Reveles, the Healthy Eating and Active Living coordinator for Lake County.”

“ ‘We’re working on improved access for youth opportunities, from volunteer opportunities, to internships, to career paths that start in school, as well as getting students outdoors and being more active,’ Reveles said.”

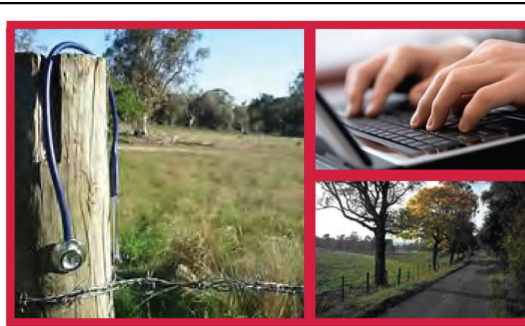
“ ‘From my perspective, there was a good shift from the youth seeing their community wasn’t really invested in them to seeing that their community was invested in their development.’ ”

“Lake County’s turn-around was one of the reasons the Robert Wood Johnson Foundation awarded the rural community a Culture of Health Prize. The annual award recognizes communities that are ‘working at the forefront of advancing health, opportunity, and equity for all,’ according to the foundation.”

“Two other rural communities also received one of the five awards given this year: Sitka, Alaska, a town of about 9,000 on the remote southern coast of the state near Juneau; and Gonzales, California, a town of 7,500 located in the Salinas Valley of Monterey County (Monterey is a metropolitan county because of the city of Salinas, population 156,000, located about 20 minutes away from Gonzales).”

“ ‘This award is for all of the Lake County community members, partners, and leaders who continue to show up and shape our community,’ said Colleen Nielsen, director of the Lake County Public Health Agency. ‘It recognizes that Lake County is headed in the right direction to ensure that our community is a place where all residents can achieve their greatest health, regardless of neighborhood, ethnicity, or income.’ ”

“In Sitka, change started when the two hospitals in the town came together to do a community health summit, said Doug Osborne, health educator at the SouthEast Alaska Regional Health Consortium and a member of the Sitka Health Summit Coalition. Started in 2006, the summit gathered community members to identify health issues they wanted to tackle each year. Some activities spurred by the effort have included building a park that meets requirements of the Americans with Disabilities Act, opening a farmers’ market, and building a racial reconciliation project. Other actions involved changing city ordinances.”



28th Annual \$2,500 Monato Essay Prize
Best Rural Health Paper by a
University of Wisconsin Student
or recent graduate. Submit by June 1st.
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“ ‘Sitka was the first community in the state to raise the age to buy cigarettes to 21,’ Osborne said. ‘And our voters passed a tobacco tax increase which made it more difficult for young adults to afford’ cigarettes.’ ”

“The community focused on being more bike and walking friendly, he said, as well as focusing on distracted driving with cell phones.”

“The community measured impact with publicly available data. And where there was no data, they improvised.”

“ ‘There [with distracted driving] we just did observations to see the impact,’ he said. ‘Just watching traffic to see how many drivers were distracted by their cell phones prior to the effort and after, we were able to see the incidence go from about 20 percent of all drivers and get it all the way down to 4 percent. In small places and rural places, you don’t necessary have the same resources as a larger place... but there are ways to measure your impact.’ ”

“Making the commitment to improving health meant setting priorities, he said.”

“ ‘I think every community would say that doing health work is important,’ he said. ‘But are you willing to do the work, that’s another story. As a country, we’re number one in what we’re spending on healthcare, but not in what we’re willing to do to be healthier. We had to make choices... on the tobacco age, our local polling showed that 70 percent of the people were for it. Still that meant that 30 percent said no they didn’t want us prioritizing [children’s] health at the expense of tobacco sellers, but it’s something we decided needed to be done.’ ”

“In Gonzales, California, community efforts have focused on economic development, opportunities for youth, and environmental sustainability. About 94 percent of the community is Latino, and one third of residents are younger than 18. The community passed a half-cent sales tax in 2014 to support youth activi-

ties, improvements in parks and recreation activities, and career training.”

“The Culture of Health Prize rewards community that ‘define health in the broadest possible terms, create conditions that give everyone a fair and just opportunity to reach their best possible health, harness all aspects of the community, and show measurable results,’ according to the foundation.”

“Communities win a \$25,000 prize and join a network of other prize-winning communities.”

Leadership Insights: “Leading with Grief”

The *Leadership Insights* series is by Jo Anne Preston, RWHC Workforce & Organizational Development Senior Manager. Back issues at www.RWHC.com.

“What follows is from decades of my own experience with life’s tsunamis which has taught me a few lessons about leading while grieving.”

- **Sometimes the show must go on.** “That is not all bad. Some of the most fulfilling, if not best, work I have done has been during times of the heaviest grieving. Showing up to do what you can gets you out of yourself and ‘uses you up’ for a good purpose. We are capable of more than we think we are. I write little notes to myself to remember to ‘Do my best.’ That’s all we can do anyway, and some days are better than others. As time goes on though, consider that work can be a way to numb the pain (just like food, alcohol, screen time, etc.) If you are avoiding grief with work, acknowledge it and take some time.”
- **Sometimes you need to cancel.** “Whether your show must go on or you should cancel, reschedule or delegate can be a hard decision to make in the moment of hard grief. I have found no rule or 1-10 grief scale that clears this up. If there are not a lot of other people or serious deadlines involved, if it is not difficult to reschedule or if someone else can cover for me, then I reschedule or delegate. While we are more capable than we think, there are some

things more important than work! No one on their death bed is likely to say that they wished they had worked rather than having spent a day being present for a truly significant life or death experience.”

- **Don’t beat yourself up for less than stellar moments (that sometimes turn into unproductive hours).** “This is one of those places where your record of work and leadership pays off. People will cut you some slack when they know this is a blip, not a permanent condition. Ask for help and support to sort out what output is realistic based on how you are doing and what has happened in your life.”
- **Make friends at work.** “The Gallup research on employee engagement reveals that employees who are most engaged at work have a best friend at work. Cultivate a friendship with someone you can go to and ask for five minutes of support, that person with whom you can let down your guard, have a few minutes of tears if you need to, who will help you laugh about something and remind you that it is going to be ok. It doesn’t need to be someone you hang out with outside of work even, just someone you trust and know is in your corner. BE that person for someone, too.”

When you lead others who grieve:

- **You already are.** “Look around any given meeting you attend and remind yourself that behind the work faces there is a lot you don’t know. Loss is part of life. Hold space open in your mind and heart for the possibility that someone may be grieving a painful breakup, the dream of the future they had for their teenager who is struggling with drugs, losing a dying parent, loss of freedoms or abilities due to illness or chronic pain, the many losses that come with living with alcoholism in a family and even the ultimate loss of hope-wondering if life is worth living anymore. Let knowing this guide your leadership to be a compassionate one.”
- **What does that compassion look like?** “Help people work at work. Good leading matters! Keep the bar high and help people be successful in their work. If you know of their loss, a brief comment at the end of a work note to say, ‘I’m sorry for your

loss, hope you are doing ok' means a lot. When their show must go on, say, 'You've got this. How can I support you today?'"

- **My employee is grieving over something I cannot relate to.** “I wish I could find the woman who worked for me for a short time (note ‘short time’) about 20 years ago. Her pet had died, an animal I couldn’t imagine caring about at the time. She wanted to talk to me about going to a support group and I know my manner with her was dismissive. I remember thinking, ‘Really? There are PEOPLE who need you. How can this be such a big deal?’ This is an embarrassing story to share. *Who am I to say what another person grieves?* If I could do over, I would stop my judgment and say: *‘I am so sorry for your loss. I hope the support group is helpful for you. Tell me about your pet.’* Five minutes of listening would have reminded us both that even if our experiences are not the same, **just like me, this person knows sadness.**”

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.

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