RWHC
Your partner. Your source.

Eye On Health

Review & Commentary on Health Policy Issues for a Rural Perspective - July 1, 2024

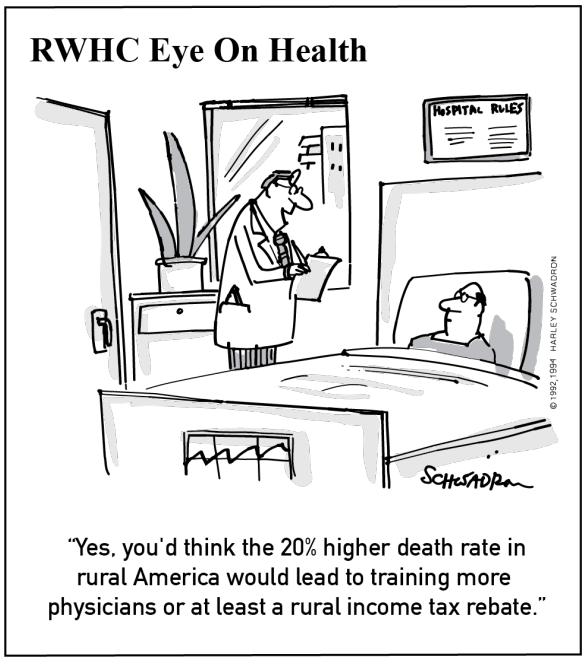
Our Underinvestment in Rural Primary Care

From "Rural Communities Face Primary Care Physician Shortage" by Liz Carey, *The Daily Yonder, Keep It Rural*, 4/22/24:

"*While rural areas now do better at training and retaining a primary care workforce, the growing demand for healthcare still outpaces the supply of doctors*."

"A recently published study from the American Academy of Family Physicians' Robert Graham Center (AAFP), co-funded by the Milbank Memorial Fund and The Physicians Foundation, has found that communities across the country are struggling to meet the demand for primary care physicians, as well as to retain those physicians in their communities. While it's difficult all over, Dr. Yalda Jabbarpour, lead researcher on the study, said, it is more difficult for rural communities."

" 'Ten years ago, we knew we had a problem with primary care physician density,' Jabbarpour said in an interview with the *The Daily Yonder*. 'Today, even though people are older, and therefore sicker, and the population is growing and the demands are higher, we actually have less physicians to fill that need.' "



"Rural communities tend to depend more on primary care clinicians, Jabbarpour said, especially family physicians."

"In 2021, 37% of all physicians in training (residents) began training in primary care, yet only 15% of all physicians were practicing primary care three to five years after residency, the study found."

"More than half of those residents with the potential to enter primary care subspecialized or became hospitalists instead, research showed. And only 15% primary care residents spent a majority of their time training in outpatient settings where a majority of the US population receives their care and fewer than 5% of primary care residents spent time training in rural and other underserved communities, the researchers found."

"The AAFP study also found that there is a slightly higher density of primary care providers in rural and underserved areas. **Looking at social drivers of health–like housing, transportation, income and education–and how they affect residents' health status, the study found that people in areas that have more social disadvantages (less adequate housing, barriers to transportation, and lower income, for instance) had higher rates of chronic disease and worse health outcomes**."

"In 2021, the overall density of primary care in areas that had more social disadvantages was 111.7 per

100,000, while the density of areas with fewer social disadvantages was 99.5 per 100,000. However, researchers said, while those measures are hopeful, they still are insufficient."



Wisconsin Healthcare Careers

https://www.wihealthcarecareers.com

" 'This finding may be attributed, in part, to the success of the community health center movement, which aims to place clinicians in areas of highest social need,' researchers said. 'Still, this promising finding needs to be tempered by the reality that even this higher density of primary care clinicians may not meet patient demands given that people living in high-need areas tend to have higher levels of medical need.' "

" 'Rural areas now do much better at training and retaining a primary care workforce, but at the same time, it's still not enough to meet the growing demand,' Jabbarpour said."

Family medicine, like any other medical specialty, she said, distributes itself the same as the U.S. population. Rural areas across the country, according to the U.S. Census Bureau, are home to 19.88% of the total U.S. population. Jabbarpour said that a correlating percentage of primary care physicians would be located in a rural area. But because rural communities tend to be statistically older and sicker, the need in rural communities is greater."

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 <**timsize@rwhc.com**>, Editor, 880 Independence Lane, Sauk City, WI 53583

www.RWHC.com

Email **office@RWHC.com** with *subscribe* on the subject line for a free e-subscription.

"One way to resolve the issue would be for more investment into primary care, the study found. Changing the overall portion of health care spending done by the Centers for Medicare and Medicaid (CMS) on primary care would help invest more federal dollars into primary care, as would investment by the U.S. Department of Health and Human Services (HHS) into new rural health clinics, health centers and Indian Health Service (IHS) facilities in shortage areas, the report said."

" 'The United States is underinvesting in primary care, and **Medicare's fee schedule–which lists fees for services–is the chief culprit**,' the report said. 'It undervalues primary care services relative to specialty services and pays on a per visit basis, discouraging non-visit services like emails and phone calls as well as care from other members of the primary care team.' "

"Jabbarpour said another key to getting more primary care physicians into rural communities is for colleges to recruit from rural communities. '**Medical schools should be recruiting from rural communities because people tend to go home to practice**,' she said."

"Bringing doctors into rural areas means helping their spouses find work as well. 'There are physicians who want to go into rural areas, but their partners don't have opportunities for work in rural areas if they're not also in medicine,' she said."

"**The biggest way to bring primary care physicians into rural areas, she said, was to expose them to it**."

" 'I know not every rural area is the same. In some rural areas, it's probably an area that physicians would love to live and grow their families in if they knew about it,' she said. 'I know that's hard because that takes hospital systems really doing active recruitment or setting up rural training tracks, and reaching out to medical schools around the country and saying, **hey, send your students here, we'll give them housing and they can get exposure to this beautiful slice of heaven that we have and then they'll want to come here**.' "

Rural Medicare "Dis-Advantage" Plans

From "Half of rural hospitals in the red, pressured by high Medicare Advantage enrollment" by Jeff Lagasse, Editor, *Healthcare Finance*, 2/15/24:

"America's rural health safety net is feeling pressured, with half of all rural hospitals in the U.S. now in the red. And according to new research from Chartis, high enrollment of rural residents in Medicare Advantage plans could make the situation worse."

"The percentage of America's rural hospitals operating in the red jumped from 43% to 50% in the last 12 months, data showed. Fifty-five percent of independent rural hospitals are operating in the red, while 42% of health system-affiliated rural hospitals are operating at a loss."

"Meanwhile, Medicare Advantage now accounts for 35% of all Medicare-eligible patients in rural communities. In seven states, Medicare Advantage penetration exceeds 50%."

"That's a problem, in Chartis' view. Traditional Medicare reimburses Critical Access Hospitals (CAHs) based on the cost of services provided. Since the advent of the CAH designation in 1997, this cost-based reimbursement has offset a rural hospital's typically low patient volume and revenue."

"But recently, Medicare Advantage has attracted an increasing number of existing and newly eligible Medicare patients. The analysis indicates that, between 2019 and 2023, enrollment in Medicare Advantage in rural communities increased 48%. This rapid increase is highlighting differences between traditional Medicare and Medicare Advantage that have unique implications for rural hospitals."

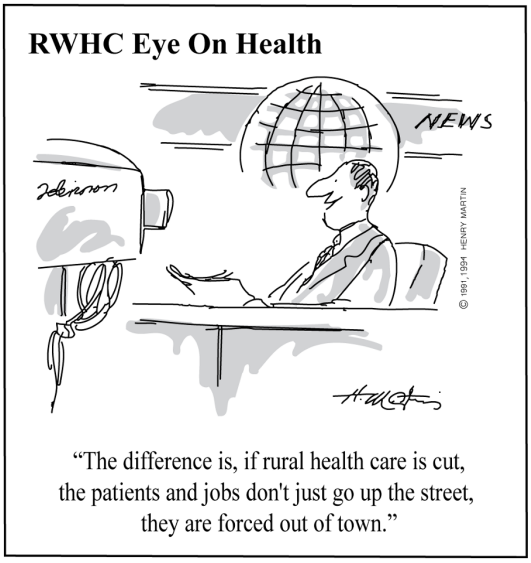
"For one, MA net reimbursement to CAHs is often lower for similar services than that of traditional Medicare because MA does not follow cost-based reimbursement. Also, MA may not cover all the services traditional Medicare does, including swing beds, which provide skilled nursing care for patients and are often a strong source of revenue stability for rural hospitals."

"Rural providers may not be equipped to efficiently navigate administrative requirements for payment introduced by Medicare Advantage, such as prior authorizations, which can lead to increased denials, analysts said. Plus, public data reporting differs for Medicare Advantage vs. Medicare claims, which may impede rural hospitals' ability to fully understand their population's healthcare experience and needs."

"According to Chartis, the number of residents in rural communities enrolled in MA increased from 6.3 million to 9.2 million between 2019 and 2023. As a result, MA plans now account for 38% of all Medicare-eligible patients in rural communities. In seven states – Alabama, Connecticut, Georgia, Hawaii, Kentucky, Maine and Michigan – that percentage now exceeds 50%. Close behind this group is a large cluster of 15 states in which MA now serves between 40% and 49% of all Medicare beneficiaries."

"Addressing the issue will require action on the part of healthcare advocates and policymakers, analysts said. In terms of recommendations, they said the Centers for Medicare and Medicaid Services' new Interoperability and Prior Authorization rule should ease the burden surrounding care approval, and that establishing greater visibility into Medicare Advantage claims data would provide a much-needed lens into how well Medicare beneficiaries are being served."

What's The Impact?–Chartis' research uses rural hospital operating margin for understanding the stability of the rural safety net. Fifty percent is the highest percentage of rural hospitals losing money in the past decade. The jump from 43% operating in the red last year to 50% this year is the single largest percentage change analysts have seen in a 12-month period."



"They also found that in 19 states, the median operating margin is in the red. States with the highest percentage of rural hospitals operating at a loss include Kansas (89% in the red), New York and Wyoming (83% each), Vermont (75%), and Alabama (74%). In Kansas, which is home to 99 rural hospitals, the median operating margin is -10%. With the exception of Delaware (home to just two rural hospitals), Utah is the only state where the percentage of rural hospitals in the red is less than 20%."

"Although rural hospital instability is national in scale, facilities in states that have not expanded Medicaid have consistently performed worse financially than their expansion state counterparts. The analysis not only shows a continuation of that trend, but a similar jump in the percentage of rural hospitals operating in the red."

"Across the 10 remaining non-expansion states (Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin and Wyoming), the percentage of facilities with a negative operating margin increased year-over-year from 51% to 55%. These states are home to more than 600 rural hospitals in total. Several of these states are among the most severely affected by hospital closures and a loss of access to care."

The Larger Trend–"While the pandemic provided a measure of stability to rural hospital finances through various government intervention programs, the data indicates that any positive residual financial affects have all but disappeared. Other government policies (such as sequestration and bad debt reimbursement) continue to chipaway at rural hospital revenue."

"For example, the Chartis analysis shows that sequestration will cost rural hospitals more than $500 million this year and the equivalent of 9,000 healthcare jobs. Cuts in so-called bad debt reimbursement (i.e., the delivery of charity care to rural patients unable to pay for medical services) will claim approximately $175 million in revenue and the equivalent of an additional 3,100 healthcare jobs."



National Rural Health Foundation

Donate to Advocacy Development

https://www.ruralhealth.us/foundation

Disagreements Don't Have to Be Toxic

From "Disagreements Are Healthy. How to Stop Making Them Toxic" by Elizabeth Bernstein, *The Wall Street Journal*, 5/20/24:

"There are many tough talks we need to have right now, about everything from the Israel-Hamas war to how to care for Mom as she ages."

"Too often, we're avoiding those productive and necessary conversations. When we do have them, we end up yelling at each other. We can just look at the unrest on college campuses to see what happens when discourse melts down."

"It's time to master the art of disagreeing–having a productive conversation when we're passionate about a topic but our opinions differ. Experts in conflict resolution have **advice that can help: Plan ahead. Actively listen. Discuss how to move forward**."

"Dr. Thom Mayer geared himself up for a tough conversation recently. As the medical director for the NFL Players Association (NFLPA), he needed to tell an athlete who'd recently had knee surgery that he wasn't ready to go back to playing."

"To prepare, he imagined how the young man was feeling and rehearsed what he wanted to say."

"Then he picked up the phone and spoke words you may want to memorize 'Hello, I need your help,' he said. 'We are going to disagree, but we are going to have a discussion.' Conversations tend to become heated because we're wired to have a fight-or-flight response when we feel threatened, especially during times of chronic stress, psychologists say."



Program Description: As healthcare leaders, our plates are full! Yet there are times we leave our work feeling empty, hungry for something different. We need sustenance to fill our own void, while gaining the energy needed to effectively fill the cups of others. Join us each month to rediscover the ingredients for success one bite at a time. In just 45 minutes, you will feast on leadership knowledge nibbles, network with others over lunch, and juice up on facilitated coaching…leaving each session with something to chew on and renewed vigor for your important work. Each subscription gives you a twelve-month banquet of rejuvenation!

Target Audience: Healthcare Supervisors and Managers, both experienced and new in their role

Food for Thought: You're not alone in your hunger. Join our Grub Club each month for recipes of success through learning practical tools and techniques, networking with colleagues with similar needs, and participating in facilitated coaching.

More Info and Registration at: https://www.rwhc.com/Services/Educational-Services/Leadership-Bites

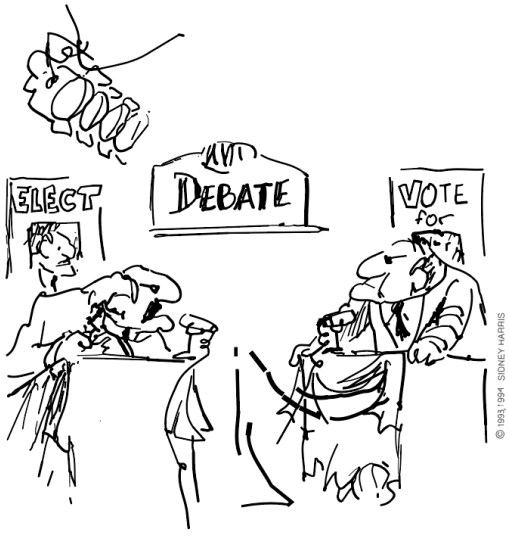
" 'Our brains treat having our ideas attacked in the same way as if our body was being attacked,' says David Supp-Montgomerie, an associate professor of communication studies at the University of Iowa, who directs the school's Civic Dialogue Initiative."

"What can we do? It's OK not to talk about a topic if you think the conversation won't be productive. Sometimes that's the best way to preserve the relationship. But if you're up for a tough discussion, here's some advice."

Prepare yourself and start off right–"Set a goal. Do you want to explain how you feel, understand the other person's point of view, or solve a problem? 'It's important to understand why you want to have the conversation in the first place,' says Supp-Montgomerie. "

"Practice your message. Write it down or rehearse it in front of the mirror in a calm tone of voice. Envision a positive outcome. That's what athletes do."

RWHC Eye On Health



"To cite Mark Twain: 'In the first place, God made idiots. That was for practice. Then he made your party.' "

"When you begin the discussion, acknowledge up front that you may not agree but you want to talk so you can better understand each other."

"Explain that you'd like to start by hearing the other person's point of view. (Be sincere!) This defuses tension and shows that you're on the same team."

"Choose your words carefully. Use 'I' instead of 'you.' (Think: 'I feel unheard.' Not: 'You're not listening.') The word 'I' comes across as less judgmental."

"And avoid the word 'but.' It negates what the other person said. **Try the phrase 'yes, and…' instead. Like this: 'Yes, I agree with you, and…**' "

Actively listen–and ask questions–"Stop waiting for someone to finish a sentence just so you can have your say. Don't interrupt. Really listen."

"Summarize what the person said and ask if you heard it correctly. For example: 'I heard you say you're upset because you think I haven't been helping take care of Mom enough. Am I right?' "

"Then ask deeper questions that get at the person's values, rather than opinions. Some good ones: 'What led you to feel so strongly about this?' 'Do you have personal experiences you can share?' 'Will you tell me more?' "

"The goal is to find common ground, says Mylien Duong, a psychologist and senior director of research at the Constructive Dialogue Institute, a nonprofit that teaches people across the political spectrum how to talk to each other. 'There are always points of agreement, even if it's as simple as you both wanting the conversation to succeed.' "

Slow it down–"If things get heated, take some deep breaths. Speak slower. Excuse yourself to grab a glass of water. "

"If you need a longer break, explain that the conversation isn't going the way you'd hoped and ask to continue it later. Then offer to take some action to further educate yourself on the subject before your next conversation, suggests Fatimah Gilliam, a lawyer and author of 'Race Rules: What Your Black Friend Won't Tell You.' This builds trust, she says."

Discuss your next steps–"Ask the other person how he or she wants to move forward. And remember, it's OK to agree to disagree."

"If you learned something, say so. That's both validating and reassuring, says Elizabeth Esrey, a professional mediator, who has worked with families, gang members and with the Truth and Reconciliation Commission in South Africa after apartheid ended."

"And thank the person for his or her willingness to talk. 'People are giving you the gift of their time even if they disagree with you,' Esrey says."

"Mayer, of the NFLPA, has developed strategies for difficult conversations. He practices his message, cuts to the chase quickly and listens closely."

" 'The goal is not to 'win' the conversation, but to communicate important, if difficult, information in a way the other person can process and be heard themselves,' he says."

"Before his talk with the injured player, who was hoping to get signed to a team, Mayer tried to imagine the pain of having a career-sidelining injury. He explained his point of view–that the player needed to take more time to recover–and listened patiently when the athlete argued with him. 'You are a great person, but we have to stick to the science,' Mayer says he replied."

"The player took his advice, he says. And earlier this month, Mayer received a call from him with happy news: He'd recovered fully and signed to an NFL team. Mayer says he thanked him for the difficult conversation."

Leadership Insights: "Accountability"

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

The buck stops … where? The work has to get done but between task identification and final completion, it can feel like herding cats.

A common challenge in healthcare is getting people to do tasks that are important to you but not as urgent to the individuals you need it from. If you manage any area of compliance, you will need something from everyone, e.g., mandatory education completed, time cards submitted, health screenings done, safety/risk issues reported, etc. It's easy for an employee to think, *"That's why we have a coordinator role for those*

things." But there is nothing to coordinate if everyone doesn't do their part.

When you hold yourself to a high standard of accountability, your stress may build when others don't share that same standard. **How do you move past frustration to get people to do what they are supposed to do, when they don't necessarily want to do it?**

Support RWHC Healthy Wisconsin



The foundation focuses on community & economic development as well as the healthcare workforce.

Email timsize@RWHC.com to discuss how you might support this work.

- **Threaten them with termination?** Not the place to start if you want engagement. Too often we start here with the "stick" approach, hoping fear will bring on compliance. The tricky part is that **employees *do* need to know up front what accountabilities are non-negotiable**, but starting with a threat doesn't create a motivating environment.

- **Address inconsistency with peers**. *"I am holding my staff to the deadlines for these requirements. They are reporting that you have told your staff that the deadlines are not important. This inconsistency makes it hard for me to get people to do things that they would rather not do anyway. I need your support; what actions will you take to address this?"* You can offer to share how you have fostered accountability, but the other leader needs to know that inconsistency among leaders is a downward spiral for morale.

- **Update policies and procedures to be understandable and clear.** Ask employees to help you write them so that they have a ground level understanding and can have input on if they make sense or not.

- **Have some fun**. Engage a team to help come up with creative and fun ways to do those health screenings. Liven up mandatory education so that even if there is dreadful screen time that it includes a game, contest, food prizes, follow-up in-person discussions, etc.

- **Communicate.** I know; your head may hurt from all the communication you believe you have done but it is human nature for people to wait for the WIIFM (What's In It For Me) to kick in. Spend less energy on why they won't comply and more on answering the questions on the minds of the people you want to engage:

WHAT? Just what is it you are asking people to do? People are smart about different things. We make assumptions that others understand all the things that we understand. Give more thought to how you explain what you want from people and the bottom-line target you are after. When you've done that, ask them for what they are taking from your request to make sure that the message was delivered and received as intended.

WHY? Appeal to the heart. I don't like filling out forms any more than the next person. But if you can share a true story about how a child was saved in the OR because a housekeeper on staff reported a safety issue in that form, I'm going to remember that story every time I am reminded to fill it out myself. *"It's a required regulation"* is not an inspirational motivator for everyone. Intrinsic motivation derives from connection to purpose.

HOW? More often than we want to admit, we ask people to do tasks or processes that WE know how to do, have told or shown them at least once (or more) how to do it, and they ought to know. Telling is not teaching. The time dedicated to build competence in a new accountability is nearly always underestimated, and especially so for those low frequency tasks. **Teach back. See one, do one, teach one.** Like purpose, mastery of skills is an intrinsic motivator so create an environment of success in learning.

WHEN? What are interim due dates and exactly what is due when? No one has all the details that you have so be clearer than you might think you need to be. Where you can, allow choice about the when, e.g.,

"This can be completed now or in the month before your performance review. When would you like to set your own deadline within that parameter?" **And a fun fact: asking people to set a time and *place*** to do a task dramatically increases their likelihood of completing it. Allowing some choice in the time frame is one way to foster autonomy–the third key component of intrinsic motivation–even if the final deadline is not up for discussion.

WHO? As with most aspects of leadership, accountability is higher when relationships are strong. Highlight how the work to be done impacts others on the team and patients. Two kinds of power in leadership are position power and relationship power. You can fire people from your position power, but you can get their best work if they know you care about them as a person.

"Chasing people down" *is* a strategy, but take the long view on this one. Once you find them, teach them a new way to treat you and the tasks you are asking of them. Build the kind of relationship where they won't want to let you down. Answer the questions above. Facilitate *their* problem-solving skills. Next time, you might not have to chase them down.

*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.*

Upcoming RWHC Leadership Programs*

6/25: **Customer Service Delivered with Excellence****

7/2: **Lateral Violence: Dealing with Disruptive Behaviors** (Hybrid)

7/16 & 23: **Become a Dynamic Communicator** (2-part)**

7/18 & 25: **Empowering vs Enabling** (2-part)**

7/24: **Creating A Pathway to Professional Growth** (1.5 hour)**

7/30: **Writing a Business Proposal & Mastering Negotiations**
(Being held in Medford, WI)

*Non-Members Welcome. **Virtual. Register & other events:
www.RWHC.com/Services.aspx

Space Intentionally Left Blank For Mailing