Public Hearing – April 15, 1999
Legislative Initiatives Proposed by the Council for the Deaf and Hard of Hearing

I am in support of the initiatives proposed by the Council; the statute for sign language interpreters, the increase in GPR dollars for the Service Fund, and the funding of the Community Service Associates through the Office for Deaf and Hard of Hearing.

However, I have several concerns regarding the draft administrative rules on the Interpreter qualifications.

QUESTIONS REGARDING THE PROPOSED ADMINISTRATIVE RULES ON THE STATUTE FOR INTERPRETER LICENSURE

Thank you for sharing this draft copy of the administrative rules with people around the state. It is an important piece of legislation that can support quality assurance for people who are Deaf, Deafblind or Hard of Hearing when receiving interpreting services in serious medical, mental health or legal settings. The Registry of Interpreter for the Deaf (RID Inc.) is a professional organization that has established guidelines for interpreter ethics, and assessment of interpreting competency as well as support on-going professional development. In recent years, RID has been working with the National Association of the Deaf (NAD) to combine assessment tools. I do support the work and efforts of RID to establish and maintain quality interpreting services to people who are Deaf, Deafblind, or Hard of Hearing. However regarding this proposal, I do have some questions and concerns about specifics.

1. Who was on this committee? Since this proposed statute represents Wisconsin, were there people from throughout Wisconsin? Or was this a group primarily from Milwaukee where services are more plentiful? Were there representatives from the facilities and agencies who will be affected by this statute?

2. The statute addresses the need for professional development. Were representatives from interpreter preparation programs in Wisconsin a part of this committee? They are not mentioned within the body of the proposed statute and are conspicuously missing on the review board that is claiming power to determine what professional development will be required of those who violate this statute.

3. Will dollars be set aside for this professional development? Will there be guidelines that protect conflict of interest i.e. so that members of the review board will not only propose the professional development but also be the agency providing it? Where will the training occur? Will it be consciously provided in the areas of the state where the need is greatest i.e. the western and northern sections of the state?

4. For (6) there is the statement "… is currently certified **and who provides true and accurate communication...**" (emphasis added). This statement creates a policing nightmare. If RID certification is valid, but only for some, who will make the judgement calls regarding "and who provides true and accurate communication? This statement

implies that RID certification does not meet the need. Does this imply that Wisconsin will establish its own assessment in addition to the national assessment that will be more valid that the one nationally recognized? Who will do this? Is this a double standard? Does this make the requirement more stringent than national requirements?

5. Under the Legal Situations, there is the requirement that interpreters working in legal setting " ... must possess current legal certification through the national RID and must have successfully completed the legal interpreter training through the Wisconsin Legal Institute or another accepted legal sign language interpreter training program defined by the department." A member of the committee that drafted this statute runs the Wisconsin Legal Institute. There is a conflict of interest in this statement as well as a statement that discredits the training that is provided on a national level by qualified trainers and recognized by the RID. I do have concerns about this language promoting a particular person / agency over others.

6. Under Sanctions, I have several concerns.
   a) What is an "education letter"?
   b) What are the guidelines for determining 1st, 2nd, 3rd ... offenses? Could someone be found to have 4 offenses in one week, before they are aware of the process in place? Or does one offense include an overall situation where a "complaint" was filed?
   c) Under (2)(a)(2) Interpreters shall be fined $500.00 ***and*** a requirement to participate in professional development as defined by the review board. (emphasis added)
      1) the $500.00 fine for a second offense is steep
      2) *...AND professional development as defined by the review board.* The review board does not have a member who is involved in interpreter preparation. Again, the agency in Milwaukee that was involved in drafting this proposal, wishes to become the agency for professional development statewide. I see a conflict of interest in the review board being the agency that designs the required professional development.

      3) The jumps between the penalties are steep and severe. Regarding "the loss of ability to practice in Wisconsin for a period of five years ...", does this mean to interpret in serious medical, mental health, and legal settings? Or does this mean that the interpreter cannot interpret at all?
   d) I am puzzled as to why interpreters ***must* participate** in professional development activities and individuals ***may* participate**? In addition, "individuals" are not barred from practicing for the 5 year time period that is placed on interpreters? Does this say that "individuals" may continue to interpret? Who are the "individuals", family members?
   e) Agencies and Facilities are fined and ***may*** *be subject to corrective action*? Why is it that **interpreters "must"** and **facilities "may"**? What will constitute a violation? Will this be different for facilities in more rural Wisconsin where RID certified interpreters are not available? How many phone calls must be made and how far before the police dept or hospital is found out of compliance? What is the corrective action? This is a clear imbalance of penalties.

7. Finally and of greatest concern is the design of the review board.
   a) In this proposal, the review board is given a tremendous amount of authority to determine violations and the penalties imposed including the professional development and the corrective action. Yet, there are no agency or facilities representatives nor anyone from an interpreter preparation program on this board. In addition, what role is the parent to play on the board? This position does not make sense in light of the overall proposal.
   b) "Upon receipt of the complaint, the review board may temporarily suspend an interpreters ability to practice." This statement is one of guilty until proven innocent. And does it mean that the interpreter can not interpret at all? Or just in the settings addressed in this statute?
   c) The timeline of 10 days for the interpreter's right to appeal is unreasonable.

This statute will affect agencies statewide in a significant way. Have all Wisconsin police departments, courts, hospitals and mental health facilities, and interpreter referral agencies been given a copy of this proposal for their review? How are the agencies and facilities included in this process? The timeline for response (April 16, 1999 – less than 10 days) is a narrow window for comment.

Again, I want to reiterate that I do support quality assurance for interpreter services for Deaf, Deafblind and Hard of Hearing people in Wisconsin. The RID certification process is a valid measure of competency, and there is need for interpreters to continue their professional development in specific fields in order to be able to provide the level of service needed. While this draft statute is a good beginning, I hope that the state is willing to address and clarify specific areas. I also hope that this committee will view alternate proposals emphasizing participation from all areas of the state and with input from a wider range of people invested in this work in order to develop a fair and comprehensive statute that addresses the need while also addressing the potential for conflict of interest by a small group of people or one agency to design a statute that creates a business niche in development of the professional development etc.

Thank you,

Carol Schweitzer
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Wisconsin Public Health Association

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WRITTEN TESTIMONY TO
THE JOINT COMMITTEE ON FINANCE
CONCERNING THE 1999-01 BUDGET
April 15, 1999

On behalf of the Wisconsin Public Health Association (WPHA), an organization representing over 350 public health professional throughout this state, we ask that you reevaluate the budget recommendations of the Governor at it relates to the *tobacco settlement.* The Governor's proposal allocates less than 2% of tobacco settlement moneys to measures to keep our young people from taking up this deadly, addictive habit or to assist Wisconsin citizens who want to stop smoking.

We urge you to take a hard look at the Governor's proposal and the longer term health improvements and cost-savings that could accrue through more decisive commitment to smoking prevention and cessation programs. By committing so few dollars to anti-smoking initiatives, the Governor is asking the taxpayers of Wisconsin to continue to pay out $200 million a year in Medicaid expenses to treat people with tobacco related illnesses. In addition, citizens will also continue to pay higher insurance rates and higher prices for products due to the high cost of illness care.

Anti-tobacco programs work. States such as California, Massachusetts and Florida have documented successes in reducing cigarette consumption and reduced smoking rates among their youth as results of strong legislative leadership and proper funding. This is a once-in-a-lifetime opportunity to make an historical impact on the public's health in Wisconsin. You will make a difference on the lives of our young people now and in the future by helping them say no to tobacco; you will reduce the costs of illness care and prevent premature deaths due to heart disease and cancer.

The tobacco settlement funds were intended to be spent to overcome *the #1 preventable health problem*: tobacco usage. The time to make a difference for our future is now.

WPHA supports the Trust campaign and the recently introduced bill of Senator Robson and Representative Urban to set aside a minimum of $50 million annually to fund smoking prevention and cessation programs.

Barbara Theis	Peggy Hintzman
WPHA Board Member	WPHA, President-elect
Mauston, Wisconsin	Madison, Wisconsin

TO: Members, Joint Committee on Finance

FROM: Terry McGinnity, Administrator, Lodi Good Samaritan Center

DATE: April 15, 1999

SUBJECT: Nursing home wage pass-through

I respectfully ask the Committee to consider a Medicaid wage pass-through for nursing home employees. The Governor's budget as proposed will likely worsen an already near-desperate situation: high turnover rates and chronic staff shortages threaten the industry's ability to continue delivering quality care. Please consider the following:

1. Medicaid reimbursement is already significantly less than our incurred Medicaid costs. Self or private paying residents are forced into subsidizing the Medicaid deficit, often times hastening their addition to the Medicaid rolls.

1998 MEDICAID GAP

$110.42	Medicaid cost per patient per day (Medicare carve-out)
$98.91	Medicaid reimbursement per patient per day
$11.51	Medicaid gap per patient per day
DEFICIT	21,174 Medicaid patient days @ $11.51 = $243,713

1998 PRIVATE RATES: $142.05 per day (excludes pharmacy)
($52,000 per year plus medications)

2. The Governor's budget proposes a 1.77% Medicaid rate increase in the first year of the biennium and 1% in the second year. These increases will fall short of the cost inflation we are experiencing (4.98% in 1998).
Factors contributing to our escalating costs include wage pressure, agency staff costs, and increased acuity levels of patients/residents.
Resulting budget constraints make retaining staff difficult. Staff shortages have led to increasing reliance on expensive agency or "pool" help, and has demanded overtime hours from remaining staff.

(PLEASE TURN OVER)

3. The following provides an overview of our staff retention difficulties:

1998 TURNOVER RATE

Certified Nursing Assistants:	41%
Licensed Practical Nurses	44%
Registered Nurses	8%
Laundry Staff	67%
Housekeeping Staff	17%
Cooks	100%
Nursing, Clerical	100%

Agency staff expenses:	$59,260
Overtime expenses:	$64,342

4. The following is a brief description of our 1999 pay scale:

Position	Starting Wage	Average Wage *	Range *
CNA	$8.27	$9.59	$8.35 - $11.54
LPN	11.11	13.82	11.11 – 15.51
RN	14.63	17.81	14.73 – 20.44
Cook	8.27	9.07	9.07 – 9.58
Other Dietary	6.60	7.80	6.78 – 9.64
Housekeeping	6.60	8.51	7.50 – 9.20

5. The following describes our recruitment difficulties:

Position	Budgeted FTEs	Average # of Vacant FTE Positions	Average Length of Time to Fill
CNA	33.0	2.5	90 days
LPN	6.5	1.5	180 days
RN	10.0	0.5	60 days
Cook	2.8	1.0	110 days
Housekeeping	4.0	1.0	240 days

* Includes higher wages chosen in lieu of benefits for many employees

April 13, 1999

To Whom It Concerns:

My name is Ingrid Forgy. I am the Director of McFarland Outreach and Special Services Department. My staff has been assigned the responsibility to work with the older and disabled adults in McFarland and six townships in SE Dane County.

As service providers, we have become increasingly frustrated and discouraged by the lack of funding for the frail and isolated adults who so desperately need financial support in order for them to continue to live in their present housing. The number of people over the age of 60 and the complexity of their needs are growing at an accelerating rate.

Hospitals are releasing these individuals to their homes before they are truly prepared to care for themselves. Nursing homes are not admitting people unless they show a strong "nursing" need. Assisted living opportunities are limited due to the facilities being filled to capacity; many of the "most desirable" homes have waiting lists.

The Dane County Human Services Department reports that there are presently 1,696 persons on the COP (Community Options Program) waiting list. They expect to service only 77 new clients in 1999. That means that 1, 619 current people have great medical and financial needs but may not receive any assistance for up to three years. I find that to be outrageous!

I ask you to make this vulnerable population a great priority. Your beloved family member or dear friend may be the next one affected by the present lack of funding, if they haven't been already. This issue will affect all of us who are fast approaching the 60's age group.

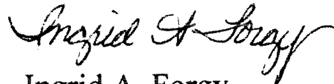
It is my request that you increase funding to decrease the COP waiting list dramatically and for new clients to be reassured that within a few months they will receive the financial support that they so desperately need for them to continue to live a dignified life at home.

It is because of this that I support the "Family Care" pilot programs. I especially feel that people should have equal access to care, whether they reside in their own home or in a nursing home. Therefore, I believe both home or community care should be entitlement programs. Funding a person to remain in his/her own home is far less expensive than to finance them in a nursing home.

I would also like to see additional dollars designated to focal points (Senior programs), specifically the Outreach workers. The workers are the front line people who assist the older adults in finding the financial assistance and resources in order for them to remain as independent and safe as they can be in their own homes. Therefore, we need adequate funding to hire enough staff with enough hours to effectively get the job done.

Thank you in advance for listening to our department's concerns.

Sincerely,



Ingrid A. Forgy
PO Box 110
McFarland, WI 53558
608 838-7117

April 15, 1999

Mr. Chairman and Members of the Joint Finance Committee

My name is Bruce Borden and I represent EBTIDE and myself in support of providing the requested funding through the budget adjustment bill for the LONG TERM CARE REDESIGN TEAM'S demonstration projects known as "Family Care" and "Pathways to Independence."

- SSA says there are 6,000,000 persons in America with severe disabilities who want to work
- AAPD projects the gross earning to be in excess of $195,000,000,000 when we achieve our employment goals
- The projected tax revenue on that income for state and federal government exceeds $80,000,000,000
- American Taxpayers richly deserve the contribution disabled citizens will be able to make when the barriers to employment are removed
- We wish to commend the Department of Health and Family Services on the level of involvement and inclusion of persons with disabilities in the redesign effort. To my knowledge the degree of interaction has been unprecedented in American History and the results are spectacular
- "Pathways to Independence" is the most visionary barrier removal demonstration project in the nation

The eyes of America once again are turning toward Wisconsin for providing innovative leadership. I ask that you embrace our vision and join us in removing barriers to employment for persons with disabilities.

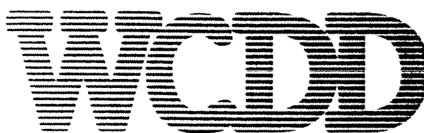
"Pathways to Independence" is providing the safety nets that will allow me to begin my journey of upward mobility, regain my status as a tax paying citizen, and return my fair share to the economic base.

I will, through my efforts, take what has been only a dream and make my American Dream a reality.

Respectfully submitted,

Bruce G. Borden

State of Wisconsin



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Council on Developmental Disabilities

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Date: April 15, 1999

To: Rep. John Gard, Co-Chairperson
Sen. Brian Burke, Co-Chairperson
Joint Committee on Finance

From: Irma Gosselin, Member
Wisconsin Council on Developmental Disabilities

Re: Selected Portions of the 1999-2001 State Biennial Budget

Thank you for the opportunity to speak today. I am Irma Gosselin, from Mukwonago, and I am representing the Wisconsin Council on Developmental Disabilities. I am addressing two issues today: special education for students with disabilities, and housing services for people with disabilities.

Special Education: The Council is very concerned about the proposed freeze in funding for Categorical Aids for the reimbursement of special education costs. Current state law obligates the state to reimburse 63% of the costs school districts incur to adequately and appropriately educate children who need special education. The state has not funded Categorical Aids at the 63% rate, however, since the 1984-85 school year. Other states reimburse an average of 50% of the costs of special education services.

People with disabilities need to be educated to the maximum extent in order to obtain and hold a job and live independently. School districts must provide special education services for the benefit of the children and society as a whole. At the same time, it is unfair to place the financial burden for these services upon school districts with less and less state support. Because of the revenue caps, local school districts are forced to make tough choices about where to reduce funding to support the educational needs of children with special education needs.

The Council strongly supports additional funding to raise the state reimbursement rate to 63% of the costs of special education services. The Council also supports retaining the statutory requirement that the state reimburse 63% of the costs for special education.

Housing Pilots: The Department of Health and Family Services had recommended to the Department of Administration the inclusion in the biennial budget of 6 housing resource pilots located around the state. The cost for the pilots over the biennium would total $504,000 FED. While the pilots were underway, grant funds from the Department of Housing and Urban Development would be secured to fund the projects in the next 2001-2003 biennium.

Each pilot would provide housing consultation and assistance to low-income households with a member with a disability. The type of assistance provided would include advice on home

ownership and financing, and technical assistance on making homes accessible and barrier-free. Each pilot would cover a multi-county area.

The Council strongly supports establishing the housing pilots. Obtaining and owning housing in the community is a continual problem for people with developmental disabilities. Individuals need more information about resources, and assistance in matching these resources to their own circumstances and preferences. The cost of $504,000 FED over the biennium is a minimal amount to help individuals live in the community.

Thank you for your consideration of this testimony.

WISCONSIN STATE BUDGET 99-01

1. Name----James Damos, M.D.

2. Who am I representing????

    a. I am speaking for the Department of Family Medicine at the University of Wisconsin

    b. Six rural communities around the state of Wisconsin that are now hosting physician rural training programs

3. What are we concerned about????

    a. Core federal funding for AHEC ends in September, 1999.

    b. AHEC's operating budget is $1.56 million in combined state and federal funding for the current fiscal year.

    c. Without additional state funds, AHEC's budget will be reduced by almost 50% and it's ability to maintain current staffing and programs will be compromised.

4. Why am I interested in this?---I am a family physician. I have;

    a. 10 years of practice experience as a rural physician in Sauk County and

    b. 11 years of academic-teaching experience with the University of Wisconsin Department of Family Medicine.

        1. While at UW, I have participated with others in developing a statewide project to train and subsequently attract physicians into rural careers.

    c. I am now returning to Sauk County to Baraboo to be the program director of one of the six rural physician educational training programs in family medicine that has developed in Wisconsin.

    d. Baraboo, being the first accredited rural physician training program in Wisconsin is currently serving as a model for other programs around the state and around the country. (Just returned from South Carolina)

5. What is the goal of this new educational strategy to train physicians in rural communities?

a. Our goal is to attract physicians into underserved rural communities where there continues to be a problem with access to health care.

b. Through these programs, we are trying to match the learner's needs with the teacher's strengths. No one can teach rural medicine to a learner like an experienced rural physician. Rural physician role models are needed as they are lacking in University academic training centers.

6. Is this an experimental program or does it really work????

a. There are currently 30 rural physician training programs in the United States similar to the Baraboo Program. Some began back in the late 1970's. National studies have shown that 76% of the graduates of these programs have chosen rural practice as a career, compared with 30% of all family medicine residency graduates.

b. Other physician training programs similar to Baraboo have developed around the state of Wisconsin in such communities as;

1. Antigo
2. Black River Falls
3. Prairie du Chien
4. Mauston
5. Menomonie

The sponsoring institutions for these sites are the University of Wisconsin Department of Family Medicine and the LaCrosse Mayo Family Practice Residency, each sponsoring 3 sites.

7. Has the development of these rural physician training programs had an effect on the communities in which they are located????

a. Two pilot studies have been done; interestingly by local rural physicians through the "Teachers for Tomorrow" program hosted by the University of Wisconsin Department of Family Medicine. Both studies have shown positive impacts of these educational programs on the community from the standpoint of;

1. physician recruitment (a big problem before the educational programs were there), physician retention, and physician job satisfaction.

2. support for the local clinic and hospital and

3. increased esteem of the rural medical campus in the eyes of the public due to the presence of the educational program. In addition,

b. An offshoot to rural AHEC activities that is resulting in positive affects on rural communities in addition is a Tricounty Agricultural Health and Safety Project in Sauk, Juneau, and Adams counties that is currently under development.

6. How has AHEC helped???

   a. AHEC has been extremely instrumental in;

      1. funding startup expenses for these programs

      2. facilitating and promoting networking

      3. setting up systems for distance education

      4. and promoting expansion of the physician rural training concept.

   b. With an anticipated 50% cut in it's budget, these programs will likely have diffuculties since Medicare graduate medical educational funding is also decreasing.

7. The solution????

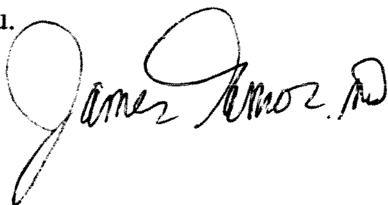
   a. Since these programs are just developing now, AHEC is seeking an additional $700,000 in state funding for each year of the next biennium in order to maintain its programmatic initiatives in underserved areas around the state.

   b. Additional funds will likely be needed in the future to sustain these programs as AHEC support is for startup only. The Department of Family Medicine at UW will be applying for these sustaining funds as another agenda item in the future.

8. In summary

   a. These projects are indeed worthwhile and have been proven as effective strategies to attract physicians into underserved areas. They have had positive effects on the rural communties in which they are located and I would urge you to consider increasing the funding to AHEC during this next budget cycle.

Thank you.



EARLY CHILDHOOD PROGRAMS OF EXCELLENCE

What is the ideal environment we adults can create for children living in Wisconsin who are aged three to five years old? Why do we need to do more for them than is already being done? Who will be responsible for carrying out this vision?

The ideal environment for early learners will provide for exploration, language stimulation, exercise, space and superior teachers. Children learn through "hands- on" exploration of materials, games, toys or found objects. Contrary to computer game manufacturers' claims, children need to touch, to drop, to mesh, to pull apart, to attach, to copy, to manipulate and they need to do it over and over again in order to truly comprehend such concepts as heavy, square, round, light, sticky, hard, soft, pointed, slick, rough, triangle, back, front, corner, and so on. The ideal environment, in addition to providing for exploration, must provide windows which provide natural light. Besides being healthier for growing brains than fluorescent light, natural light can be a source of science instruction. Tiny seedlings will grow in window sills. Weather phenomena can be observed and discussed. Windows are essential. An ideal environment will offer a multitude of surfaces. For cozy circle times, a carpet is a must. For messy art and exploratory work, a scrubbable vinyl floor surface is necessary. For quiet times, soft cushions relax little bodies. For private times, a loft to climb to is great. For riding and running, an large unencumbered space is required. Finally, an ideal environment will extend outdoors. A variety of climbing and swinging equipment is a must. Wood chips piled beneath provides a soft cushion to tumble onto. Sizable grassy areas provide runners a chance to let loose. A small area in which to garden and search for creatures can present innumerable science lessons. Clearly, an ordinary classroom within an elementary school is unable to provide these requirements and presents as a poor substitute. Yet, in most school districts, the neediest of the 0 to 5 year- old population, those students with developmental delays are placed in classrooms or church basements built for older students. The rest of the 0 - 4 year- old population experience a variety of settings from small homes to home day care or franchised day care centers, few of which provide the ideal learning environment. How could they? They are not designed primarily for learning, but for care-giving.

Language stimulation is more necessary now than it was even one generation ago. More children have working parents who are too busy to think out loud in front of growing children. The number of speech and language referrals for therapy in the public schools is sky rocketing. Television does NOT teach a child how to communicate effectively. Computers certainly do not either. Busy day care givers do not have time to ask children to articulate or to repeat their phrases in correct syntax. An ideal environment for early learners should have a speech therapist on staff who will mix speech delayed students with regularly developing talking peers as frequently as several times during each school day. Older students should be carefully mixed in with younger ones to also generate language. Staff must be adequate in number and in training to promote age-appropriate language levels for all students; the at-risk children, the normal children and the developmentally delayed.

Growing children need exercise. Movement is the foundation of all learning. A growing number of early childhood educators realize the valuable effect movement has on a child's ability to learn, to concentrate and to function in society. Our governor has read the newest literature on developing brains, too. He is aware of the needs. Once again, busy parents aren't able to provide the movement diet necessary for neural transmissions to fully develop in the brains of their children. Some children will seek the swinging, hanging upside down, wheelbarrow walking and jumping that they need. Some children only need the "normal" amount of activity parents can provide. Many children need more. They need daily, structured movement to insure that they don't become too restless in grade school. Attention deficit- type behaviors may result from lack of daily large body movement. Socially unacceptable behaviors also arise from lack of desensitizing movement lessons. Years ago, farm children got all the movement their bodies required. Suburban and city children, sitting in front of a monitor or sitting on a bench waiting a turn to swing at a ball or do their front roll up do not receive this sensory diet of necessary movement. Specially trained occupational therapists can work with early childhood teachers to provide a large preschool population with appropriate movement and sensory integration.

Cognitive instruction can be given across many settings. Instructional games provide children with the materials to explore and learn from mistakes. Computer games teach vocabulary and also reinforce correct answers. One-on-one instruction is very valuable. The best early learning center would provide children with all three means of learning: self-correcting games and materials, computer games and teachers with experience and knowledge of all the channels through which young children acquire information, store that information and generalize it to think abstractly.

The most ideal learning center only has the students for a few hours a day. The remainder of a student's day is still spent with busy parents or day care providers. We are finding more and more parents are not as proficient at parenting as they are at their jobs or hobbies. High schools offer a parenting course which probably instructs 1/20th of a graduating class of seniors. An early learning center must provide parents with resources to read, educational games to borrow and support groups to attend. Parenting classes should be offered each semester, one during the day where parents can interact with their children and simultaneously receive professional pointers. Another class should be offered at night with baby sitting provided. There is more information available now on how developing brains can best be nourished and stimulated. Grandparents can't offer this kind of support or advice because it wasn't known in their day. The early learning center must take the place of neighborhood coffee groups, family gatherings and other settings where young parents used to acquire answers to parenting dilemmas.

Early childhood teachers have limited opportunities to broadcast this kind of information. Fortunately, our governor, Tommy Thompson, has become aware of these very critical pieces of the puzzle of how to raise whole, independent, critically thinking and caring students. These students will be Wisconsin's future. Our hope is that law makers, perhaps in partnership with businesses, can see the way to providing the youngest citizens of the state with the brightest futures.

Submitted by: Doris D. Kimball, Early Childhood Teacher, SWD
P.O. Box 130, Wales, Wisconsin, 53183

Policy Group on Welfare Reform

A Coalition of Religious Groups, Direct Service Providers and Non-Profit Organizations

310 North Pinckney Street, Madison, Wisconsin 53703 *Telephone: (608)251-4834*

1999 W-2 LEGISLATIVE ISSUES

After a year of operation, it has become apparent that W-2 must be changed if we are to succeed as a state in moving people out of poverty and into the work force. The Policy Group recommends that the legislature make the following changes:

1. Expand education and training opportunities and support to enable families to escape poverty and become self-sufficient.

a. Allow those who lack basic skills, English language skills, and high school degrees, to concentrate on mastering those skills and obtaining degrees by being assigned up to 30 hours per week for education and training. Stipulate that any work assignments may not be allowed to interfere with their progress toward achieving these goals.
b. Provide that W-2 participants may pursue post-secondary training likely to lead to improved employment opportunities as long as they participate in up to 20 hours of subsidized or unsubsidized work activities, remain in good standing, and make reasonable progress.
c. Provide for child care eligibility for non-W-2 parents in education and training programs without a work requirement if they meet financial requirements, are in good standing, and are in a program likely to lead to employment.

2. Provide better income support for families of marginal workers to prevent destitution of children.

a. Pay benefits to all applicants who meet eligibility requirements, deemed "job ready" or not, within 30 days. Those required to do an up-front job search should be placed in a W2 work activity after 30 days, if they remain unemployed, and receive W-2 benefit payments for the month of job search.
b. Require agencies to place low-income, part-time workers in W-2 work or training positions and provide pro-rated W-2 benefits.

3. Provide accountability and fairness in the system by restoring fair hearings and continuing benefits and providing a mechanism for participants to evaluate the program.

4. Improve access to W-2 and assessment of participants to make sure that low-income families are provided help when they most need it and are provided the kind of support they need to become self-sufficient.

a. Provide mandatory training for all W-2 agency employees in dealing with special populations, including those with issues of domestic violence, homelessness, language and cultural barriers to employment and self-sufficiency, learning disabilities, AODA or other mental health problems.
b. Require DWD to promulgate rules setting standards for individualized assessments and improved services for the above populations, including counseling, legal services, transitional and subsidized housing, child care, and instructions for using available public transportation.
c. Require DWD to promulgate rules setting standards for intake and review procedures, access to emergency assistance and expedited food stamps, telephone access to agency workers, the right to be accompanied at interviews.
d. Provide rules that also cover timely access to county workers for those applying for food stamps, child care or medical assistance without applying for W-2 benefits.

5. Improve the quality of child care, and make it more affordable and accessible in order to ensure healthy children and more successful workers.

a. Remove the requirement for co-payments for families with incomes below the federal poverty level, for foster parents and for those providing kinship care and reduce maximum co-payments to 10% of income.
b. Increase eligibility limits for child care to 225 % of the federal poverty level.
c. Restore the training requirement for all certified providers and increase the minimum training in child development.
d. Expand eligibility for in-home child care for second and third shift workers and sick children, regardless of the availability of out-of-home care.

6. Improve transportation support to all low-wage workers, including public transportation, voucher systems and help with buying cars, reinstating licenses and obtaining occupational licenses.

7. Ensure adequate support for families with adults or children with disabilities or other significant barriers to work so that the basic needs of children are provided for while parents who are able to do so are helped to become self-sufficient.

a. Increase the C-Supp benefit to $250 for the first child and $150 for each additional child of SSI parents.
b. Extend eligibility for C-Supp benefits to children of minor children of SSI parents.
c. Define as a W-2 work activity the care of a child with special needs or the care of a disabled member of the participant's immediate family.
d. Extend eligibility for child care services **to** 13 to 18 year old children with special needs.
e. Increase the benefit level for W-2T placements to equal the CSJ benefit.
f. Provide for eligibility for W-2 services (except for cash benefits) for SSI parents.
g. Eliminate the 2-year time limit for W-2 T placements.

8. Support healthier babies by providing cash assistance to pregnant women and reducing work requirements for mothers of infants.

a. Exempt parents of infants from work activities, except on a volunteer basis, for the first 12 months and provide voluntary parenting and mentoring support services.
b. Extend eligibility for W-2 work program placements to women in their last trimester of pregnancy, even if they have no other children.

9. Expand eligibility for W-2 work programs to non-custodial parents.

10. Provide special attention to teen parents to set them on the road to self-sufficiency at the earliest possible time.

a. Allow parents who are still eligible to attend high school to do so without any additional work requirement.
b. Exempt parents attending high school from child care co-payments while they are attending school.
c. Allow minor parents to apply for child care assistance on their own when a parent or guardian is unable or unwilling to do so.

11. Expand eligibility for emergency assistance to those facing evictions, and make such assistance available to this new group as well as those who are homeless once every 12 months.

These proposals are supported by the following organizations:

Wisconsin Council on Children and Families
Grandparents United for Children's Rights, Inc.
Wisconsin Women's Network Child Care Task Forces
Lutheran Office For Public Policy in Wisconsin
Churchwomen United
League of Women Voters of Wisconsin
Family Enhancement
YWCA - Madison
YWCA - Green Bay
Western Dairyland Equal Opportunities Commission
National Association of Social Workers, Wisconsin Chapter
Wisconsin Coalition Against Domestic Violence
Community Coordinated Child Care, Inc. (4 C's)
Madison Urban Ministry Justice Issues Task Force
Wisconsin Women's Network Economic Security Task Force

WISCONSIN MEDICAL ASSISTANCE PERSONAL CARE (MAPC) SERVICES
FACT SHEET

WHAT REIMBURSEMENT RATE HAS BEEN PAID BY THE WISCONSIN MAPC PROGRAM TO PROVIDERS SINCE THE INCEPTION OF THIS PROGRAM?

JULY 1, 1988	$9.00 Per Hr. PCW	$38.72/Supervisory Visit
JULY 1, 1989	$9.33 Per Hr. PCW (4% increase from 1988)	$38.72/Supervisory Visit
JULY 1, 1990	$11.05 Per Hr. PCW (18% increase from 1989)	$38.72/Supervisory Visit
JULY 1, 1997	$11.27 Per Hr. PCW (2% increase from 1990)	$39.49/Supervisory Visit
JULY 1, 1998	$11.50 Per Hr. PCW (2% increase from 1997)	$40.28/Supervisory Visit

WHAT ARE OTHER STATES CURRENTLY PAYING FOR MAPC SERVICES?

- ILLINOIS $41.45 PER VISIT
- INDIANA $14.70 PER HOUR
- MICHIGAN $12 - 13.00 PER HOUR
- MINNESOTA $12.36 PER HOUR
- MISSOURI $15.50 PER HOUR (in 1996)

WHAT ARE THE REASONS WHY THE NUMBER OF INDIVIDUALS RECEIVING MAPC SERVICES HAS NOT SUBSTANTIALLY INCREASED BUT THE UNITS OF SERVICES ARE INCREASING?

If this is indeed true as the State of Wisconsin reports, although we have not seen statistics to support this theory, the following are all reasons for the increase in MAPC units of service:

- The population of MAPC consumers is aging and needing more service. The MAPC population of recipients is chronically ill, getting older and sicker as the disability progresses.
- Consumers are referring themselves directly to MAPC agencies. They have already been in the system.
- The Balanced Budget Act of 1997 will see more consumers utilizing MAPC

services/cost shifting as Medicare pays for less and less.

- The changes in the MA PC regulations from 1992 at which time more and more home health aide hours were "bumped" down into the MAPC category.

- Natural support systems are aging, gone, dying.

- Some counties have such high waiting lists for county services, MAPC services have been maximized.

- Counties have expanded MAPC services and to Group Homes and CBRF's the last couple of years. Most of these individuals have already been in the Medical Assistance system.

- Most counties have always encouraged full utilization of MAPC services involvement to maximize MA card usage.

- The move towards cost containment by counties have cost shifted waiver costs to MA card costs.

- Agencies and counties have attempted to maximize the use of family members to provide increased services needed to existing cases. Agencies have difficulty opening new cases due to serious staff shortages in all parts of the state.

WHY IS THERE A DESPARATE NEED FOR A RATE CHANGE IN THE MEDICAL ASSISTANCE PERSONAL CARE RATES?

1. Home Health agencies, Personal Care agencies, County agencies currently have costs on the average which are higher than the MAPC reimbursement rate of $11.50/hr.(costs to provide services on average range from $13.96 to $16.40/hr).

2. There have been home health agencies who have discontinued their MAPC programs or will take no new MAPC referrals making it difficult for consumers to receive services.

3. Low unemployment rates throughout the state are causing serious personal care worker staff shortages and higher wages and more comprehensive benefits are needed in order for agencies providing personal care services to stay competitive in this labor market.

Prepared by: Jean Rumachik
Legislative Chairperson
Wisconsin Personal Services Alternatives, Inc. (WPSA)
9/30/98

JOINT FINANCE TESTIMONY 4/15/99

Hello, my name is Walter Dillingham and I live in Madison. I have been receiving Medical Assistance Personal Care services since November 1991. I am here to support a $4 dollar an hour increase in MA personal care, to be used as a wage increase for workers all over this state.

Everyday personal care workers assist me to get up, to go to bed, to make meals and do laundry. They can make more money at dozens of other jobs in Dane County and not have to work evenings, weekends or holidays at my home. Private businesses can raise their prices to pay higher wages. I need you to help my workers get a raise and keep getting yearly raises to keep them with me. If I can't find workers who will work for this pay, I would end up in a nursing home. I would rather die on the streets than be in a nursing home.

I can't do my volunteer work or my private business from a nursing home. I give back to my community every way I can. For all the seniors and people with disabilities in Wisconsin who need personal care please understand our problem here. We need to be able to compete with private businesses for

workers. The unemployment situation is desperate, with fewer and fewer people even looking for work. I need to compete on an even basis for my help.

Thank you for this opportunity to speak.

Walter Dillingham
124 Proudfit #1
Madison, WI 53715
608-255-8481

MEDICAL ASSISTANCE PERSONAL CARE REIMBURSEMENT INCREASE

TESTIMONY

By

Bob Deist

4/15/99

My name is Bob Deist. As Director of Medical Assistance Personal Care Services at Community Living Alliance and as a past president of Wisconsin Personal Services Alternatives (WPSA), I am speaking in favor of a $4.00 per hour increase in the Medical Assistance Personal Care reimbursement rate. WPSA represents the MA personal care only providers throughout Wisconsin. Currently 65 counties and 2 independent living centers are certified as MA Personal Care providers. I'm sure all of you know that currently thousands of adults with disabilities are on waiting lists for COP or waiver funding. The reason so many counties have become providers is that the MA Personal Care benefit is the only community funding readily available to serve adults and children with disabilities. To present, admissions to nursing homes or other institutions, MA Personal Care is the only immediate alternative. In addition to waiting lists, counties have had to replace home health agencies that did provide personal care but terminated their programs due to the low reimbursement rate.

The current reimbursement rate of $11.50/hour prohibits personal care providers from competing with the private sector for wages. Throughout Wisconsin, the industrial, retail and fast food private sectors are offering higher wages than MA Personal Care. As of today, CLA's Medical Assistance Personal Care Program that serves 95 consumers with significant disabilities has 53 vacant shifts. Since the program began in July 1988, the MA reimbursement rate has only increased by $2.50/hour. From 1990 to 1997, there were no rate increases at all.

With the low unemployment rate MA Personal Care providers are struggling to recruit for and retain their personal care workers. WPSA in conjunction with an initiative by counties, are asking for a $4.00/hour pass through wage rate increase that will elevate wages to a "living wage" and the ability of providers to offer health insurance and other benefits. It is only with such an increase, that we will be able to successfully compete in the labor market.

WPSA recognizes that tax relief is a priority for this budget, but we believe that this wage increase will reduce the need for higher institutional costs and therefore reduce the MA budget overall. In keeping with Governor Thompson's Family

Care goals to divert thousands of adults from nursing homes, the ability to recruit and retain community workers is essential. This wage increase will continue this diversion and build the workforce while the legislature debates the implantation of Family Care.

Thank you for your time. I am available for questions. I would like to submit data to support the increase with my speech.

Bob Deist

MAPC Director of Personal Care Services

Community Living Alliance

1310 Mendota Street

Madison, WI 53714

(608) 242-8335 ext. 113

C H O I C E S F O R I N D E P E N D E N T L I V I N G, I N C .
941 W. Fountain Street
Mineral Point, Wisconsin 53565
Telephone (608) 987-3775
Fax (608) 987-3082

April 15, 1999

Senator Brian Burke
Senator Russell Decker
Senator Robert Jauch
Senator Kevin Shibilski
Senator Gwendolynn S. Moore
Senator Kimberly M. Plache
Senator Robert L. Cowles
Senator Mary E. Panzer
Rep. John Gard
Rep. Cloyd A. Porter
Rep. Sheryl K. Albers
Rep. Dean R. Kaufert
Rep. Mark C. Duff
Rep. David W. Ward
Rep. Gregory B. Huber
Rep. Antonio Riley
Joint Finance Committee
State Capitol
Madison, WI 53707

Dear Senator Burke, Senator Decker, Senator Jauch, Senator Shibilski, Senator Moore, Senator Plache, Senator Cowles, Senator Panzer, Rep. Gard, Rep. Porter, Rep. Albers, Rep. Kaufert, Rep. Duff, Rep. Ward, Rep. Huber, and Rep. Riley:

Thank you for this opportunity to submit requests and comments regarding the Wisconsin State Budget.

On behalf of the Board of Directors of CHOICES for Independent Living, Inc, I ask that your committee consider our request for $80,000 for locally-controlled and locally-accessible independent living services in rural southwestern Wisconsin.

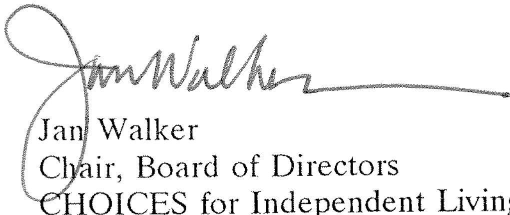
Independent Living (IL) services are aimed at all persons with disabilities regardless of age. The four core services provided by independent living centers are: (1) information and referral; (2) individual and systems advocacy; (3) peer counseling; and (4) independent living skills training. Based on local consumer/client needs, other services provided may include housing, legal/paralegal, financial/benefit counseling, vocational, education, assessment, case management, communications, transportation, social/recreational, and personal growth/self-help.

Unlike many states, Wisconsin independent living centers have been concentrated in metropolitan areas. Certainly, there is a great need for independent living services in high population areas, and it is often difficult to extend the services to surrounding rural counties. However, the geographic isolation experienced in rural areas is particularly felt by people with disabilities and necessitates different solutions for problems experienced by rural citizens.

CHOICES for Independent Living, Inc. has been formed by people with disabilities who live in southwestern Wisconsin. It is ready to provide independent living services to people living in Grant, Iowa, and Lafayette Counties. However, come July 1, there will be no independent living center funds designated to go to small, rural agencies. Ultimately, rural people all over Wisconsin will be affected by the outcome of this request.

Thank you for listening to our concerns and for considering our proposal.

Sincerely,



Jan Walker
Chair, Board of Directors
CHOICES for Independent Living, Inc.

Enclosure

cc: Sen. Dale W. Schultz
Representative David Brandenmuehl
Representative Stephen J. Freese

BUDGET REQUEST

$80,000 for a small, rural Independent Living Center (ILC) in southwestern Wisconsin.

BACKGROUND

1994 - 1997

There were many conflicting ideas about who should provide independent living services in the thirteen western and southwestern counties of Wisconsin. In an attempt to resolve these differences, the State awarded Independent Living Center (ILC) funds to Great Rivers Independent Living Services (GRILS) in LaCrosse with the requirement that they subcontract the funds for Grant, Iowa, and Lafayette Counties to the Hodan Center in Mineral Point.

From the beginning, Great Rivers Independent Living Services (GRILS) and Hodan Center had an uneasy partnership. Great Rivers did not like being required to provide services through a subcontract with an agency which provided any centrally-based rehabilitation services to people with disabilities. However, the Hodan Center believed that, without this requirement, southwestern Wisconsin would have received few, if any, independent living services. Local consumers/clients were concerned that people in LaCrosse did not understand and were not listening to their rural concerns. Often, southwestern Wisconsin is not included in the same service area as LaCrosse which, unfortunately, meant that there was no base of trust to build on or work through these disagreements.

1997 - 1998

According to the 1997 Satisfaction Survey, the independent living services the Hodan Center provided under its subcontract with Great Rivers Independent Living Services (GRILS) were rated higher by both consumers/clients and service providers in their three-county area than the independent living services GRILS provided in the other counties.

On November 17, 1997, GRILS sent a letter to the Hodan Center stating that the Hodan Center would have to end all rehabilitation services provided on-site or GRILS would not continue subcontracting with the Hodan Center after June 30, 1998. On February 19, 1998, the Independent Living Consumer Advisory Committee in southwestern Wisconsin overwhelmingly voted to recommend the Hodan Center received Independent Living Center (ILC) funding with the understanding that it would "spin-off" the ILC program to created an independent, free-standing, locally-controlled independent living center. The Consumer Advisory Committee members were excited about the potential for local control and local leadership development.

1998-1999

Hodan Center obtained funding through the Wisconsin Department of Health and Family Services' Bureau of Aging and Long Term Care Resources to continue independent living services while an independent agency was established. CHOICES for Independent Living was formed, became recognized as an independent non-profit corporation, and has applied for 501(c)(3) tax-exempt status.

1999-2000

In general, Wisconsin Independent Living Centers have been established in larger cities and include large unserved and under-served rural areas. Unfortunately, the new State Plan for Independent Living continues this trend. The Plan does not provide funding for rural Independent Living Centers. Instead, it designates only Milwaukee and the Fox River Valley as expansion areas. It strives for $500,000 and 500,000 people per Independent Living Center. This focus of independent living services in urban areas means that most rural Wisconsin residents with disabilities will live more than an hour drive from their Independent Living Center; it will be difficult to promote grass-roots advocacy for rural people with disabilities; few opportunities will be available for rural persons with disabilities to have a real voice in policies affecting their lives; and more people with disabilities will move from rural to urban areas because they believe they must do so to obtain need services.

CHOICES for Independent Living, Inc. has been formed by people with disabilities. It is ready to provide locally-controlled and locally-accessible independent living services to citizens of southwestern Wisconsin.

Dear Joint Finance Committee Members:

The Wisconsin Council of the Blind would like to bring to your attention several areas that we are concerned about in the upcoming budget. Our concerns are based on areas that significantly affect persons who are blind and or visually impaired.

1. We are concerned that funding for an inter-city transportation pilot project has been taken out of the budget by the Department of Administration. Our major concern is that inter-city transportation is lacking for persons who are blind or visually impaired, as well as for those who do not drive for other reasons. We urge your support in restoring funding that will study the need for such services. Our concerns do not simply relate to getting people from place to place, but more importantly, we are concerned about the negative impact that the lack of adequate transportation has on peoples' ability to participate in such things as employment, socialization, recreation and the general opportunity to participate in society.

2. The Business Enterprise Program is a program that provides blind or visually impaired persons with the opportunity to establish small businesses. The program began in the 1930s and under the federal Randolph Shepherd Act, states are mandated to carry out such a program.

Because of the retirement of two of the three persons holding supervisory positions in the program, and because the third position is currently held by a new person, we are concerned over the vacant positions. We urge your support to ensure that qualified persons be sought and considered for the position in a timely manner.

3. We urge your support in restoring 5 (five) positions that have been cut at the Wisconsin School for the Visually Handicapped in Janesville. As you know, a legislative study is currently underway, and any attempt to cut staffing at this time will not only seriously affect the ability to serve the children who are already there, but will also make it difficult to implement any recommendations that might come from the study.

4. We urge your support in restoring the sum of $100,000 to services for older blind. As a Council, we serve many older blind persons and work very closely with the Rehabilitation Teaching Program offered through the Office for the Blind. We recognize how important the services offered by Rehabilitation Teachers are to the lives of many citizens of this state. This program affords persons who are losing vision the opportunity to re-learn basic skills; allowing them to continue living in their own home, and as importantly, continue to be productive and involved with families and community.

As a Council, we work very closely with the rehabilitative teaching program, and in fact, the Wisconsin Council of the Blind provides $1000.00 for each Rehabilitation Teacher to meet the needs of persons who already fall between the cracks.

5. We ask your support in the increase of funding for the Library Services for the Blind and Physically Handicapped. It is our understanding that inflationary costs were added to the budget for consideration of inflationary contract costs. We urge you to support allocations in the following manner: the first year budget increase of $38,300, second year of $73,600, for a total of $111,900 for the two year period. Many of the persons we serve use the library's services to blind and physically handicapped. For most it provides a an opportunity not only to continue to read in an alternative format, but as importantly, affords the opportunity to stay in touch with their peers.

6. We urge your support for an amendment to the statutes that will provide funding for the News Line program. It is our understanding that universal service funds were in the statutes for the last budget, and that an amendment to allow statutory language to again use universal service funds would be required to continue funding. We urge your support in this area because, while the program is relatively new, it meets an age old problem for persons who cannot read print. It affords the opportunity to access news and current events in a manner that is also timely.

SPECIAL COMMUNICATION

A Case for the Development of Family Practice Rural Training Tracks

James R. Damos, MD, Carrol Christman, MA, Craig L. Gjerde, PhD, John Beasley, MD, Maggie Schutz, RN, MS, and Mary Beth Plane, PhD

Enthusiasm for alternate training sites has been strong among practicing family physicians and students seeking family practice residency positions in Wisconsin. The number of rural training tracks in the state is increasing rapidly. The University of Wisconsin currently has 4 residents in two rural training tracks. If 1998 recruitment is successful, there will be 12 residents in seven rural training tracks operated by two sponsoring institutions in the state. The Wisconsin rural training tracks are 1-2 programs,[1] in which the family practice resident spends the first year in the urban medical center of the home program completing appropriate rotations, such as internal medicine, pediatrics, obstetrics-gynecology, emergency medicine, surgery, and critical care, and the last 2 years in a rural community and rural hospital as an apprentice with a family practice group. During the last 2 years, the resident can receive longitudinal training in specialty areas with visiting subspecialists and can spend time away from the rural medical practice for specialty rotations not available in the rural setting.

The development of the Wisconsin rural training tracks was based in part on the pioneering work of Rosenthal et al.[2] The process used to develop the first rural training track was adopted as a template for developing other rural training tracks in Wisconsin and in other states.[3] Not much has been published, however, assessing educational outcomes and documenting the effects of rural training tracks on communities. Despite this lack of documentation, we believe rural tracks have merit as a training model for family practice and they should continue to be developed and studied for the following reasons:

Rationale for Rural Training Tracks

Family Physicians Are Urgently Needed to Provide Comprehensive Medical Services in Rural Areas

Compared with 9 percent of urban residents, 29 percent of rural residents of the United States live in areas with a shortage of health professionals.[4] Both the Council on Graduate Medical Education (COGME) and the American Academy of Family Physicians have recommended increasing the number of family physicians, in part, to meet the needs of rural and underserved areas. COGME also noted that while there are sufficient numbers of physicians, many generalists and specialists remain largely regionalized to urban and metropolitan centers.

An article in a recent American Family Physician newsletter[5] comments on maldistribution even within family medicine:

> Family medicine has provided thousands of physicians to underserved rural communities over the years. In recent years the number choosing rural practice have remained at about 600 per year, despite increases in residencies and resident positions. Family practice is now in danger of becoming much like the other medical specialties: as the supply increases, there is increasing maldistribution of the specialty. The only exception to this rule is urban poverty practice where family practice graduates have posted major increases. If family medicine fails to address this location issue, it will soon face more than threats to Title VII funding. Without special efforts to increase the numbers of family medicine residents choosing rural locations, much of the political power of the specialty will be lost. This could have impacts on graduate medical education funds at the federal and state levels.

Submitted, revised, 12 November 1997.

From the Department of Family Medicine, University of Wisconsin Medical School, Madison. Address reprint requests to James R. Damos, MD, Department of Family Medicine, University of Wisconsin Medical School, 777 South Mills St, Madison, WI 53715.

We contend that family medicine must not only see as its mission the need to encourage graduates to select rural practice, but it must also be prepared to provide the needed comprehensive services. Maternity care, care of the elderly, and emergency care are essential services that are often inadequately available in rural areas.

In counties with populations of fewer than 10,000, less than 1 percent of the physicians are obstetricians.[6] With obstetricians largely regionalized near urban or teaching centers, the provision of maternity care in rural communities is essentially the responsibility of family physicians and certified nurse midwives. Two thirds of women giving birth in rural communities are attended by family physicians or general practitioners.[7] Nationally, however, the number of family physicians providing maternity care has been dropping for a variety of reasons (malpractice, lifestyle, struggles getting privileges in hospital maternity care units, lack of role models during residency training, and fear of emergencies that can develop even in low-risk deliveries).[8-11]

The declining role of the family physician in maternity care is having an impact on access to maternity care in rural communities. Larimore and Davis[12] have shown that declining access to maternity care in rural areas affected the ability of Florida to reduce its infant mortality rate. Allen and Kamradt[13] suggested that decreased access to maternity care in rural areas of Indiana resulted in an increase in infant mortality. Nesbitt et al[14] found that maternity patients who must travel from rural areas to regionalized perinatal centers for prenatal care and delivery have more complicated deliveries, higher rates of prematurity, and higher costs of neonatal care.

Family physicians and general internists provide the majority of primary care services to the home-dwelling elderly and nursing home residents in rural communities. Many rural elderly are unwilling or unable to travel to urban areas to see a variety of subspecialists for their multiple medical problems. The elderly population is growing at a pace greater than that of the general population.[15,16] Currently 1.5 million Americans live in nursing homes; by the year 2030, this number could increase to 5 million.[17-19] Rural elderly represent a large population that is particularly vulnerable to health care provider shortages.

To save lives, rural hospital emergency departments must be able to manage the first hour of trauma or critical care before transfer can be made to a higher level center. Many rural family physicians have completed emergency advanced life support courses (advanced cardiac life support, advanced trauma life support, pediatric advanced life support, advanced life support in obstetrics) and routinely provide emergency services when residency-trained emergency physicians are not available. In reality, even when board-certified emergency physicians are available at a rural hospital, family physicians are called in to assist with major trauma when many victims are involved.

Table 1. Relation Between the Length of Rural Training and Rural Practice Choice.

Number of Required Rural Months	Programs with Rural Months, No.	Graduates Choosing Rural Practice, %
0	212	24.4
1	82	36.5
2	29	45.6
3	15	52.3
4-6	4	51.0
22+	11	68.5

Length and Content of Training Appear to Be Related to Choice of Rural Practice

Many family practice residencies offer residents a brief exposure to a rural family practice career through rural rotations. A short exposure might not be enough. Bowman[20] found that the more time family practice residents were required to spend in rural communities with rural physicians, the higher the likelihood of the residents choosing rural practice (Table 1). Their national survey of rural family physicians found that 31.5 percent took a required rural rotation during residency and 48.5 percent took an elective rural residency month. The same study showed that the more maternity care training a family practice resident had, the more likely he or she was to choose rural practice (Table 2).

Residents Tend to Settle Where They Train

Magnus and Tollan[21] reported that the establishment of a new medical school in northern Norway had a beneficial effect with 56 percent of the graduates remaining in remote northern areas. Lebel and Hogg[22] showed that community-based residents in Ottawa were more likely to choose a

Table 2. Relation Between the Length of Obstetrics Training and Rural Practice Choice.

Number of Obstetric Rural Months	Number of Programs	Graduates Choosing Rural Practice, %
2	14	23.8
3	11	31.2
4	71	34.1
5+	30	42.1

small community practice, and LeFevre and Colwill[23] found that residency location had an effect on practice location.

The experience of the University of Wisconsin family practice residency programs indicates that residency location is a strong determinant for graduate practice location. Dots representing all program graduates in Wisconsin (Figure 1) show clusters of graduates around the residency training sites. We speculate that if more training is moved to rural tracks, the same factors that encourage residents to practice near their urban residency sites will lead them to practice near their rural residency sites as well as in other rural sites. Bowman[20,24] recommends rural tracks as one strategy for increasing rural practice selection based on evidence from the Society of Teachers of Family Medicine study.

Urban Residency Programs Where Graduates Locate Might Have Difficulty Providing Sufficient Patient Care Experience for Residents

The history of subspecialization offers a warning. Until the 1950s, most US physicians were general practitioners who had 1 year of postgraduate training (rotating internship). In the 1950s and 1960s, the National Institutes of Health began to offer research fellowships to attract young physicians into academic research.[25] By the 1970s, research fellowships became clinical fellowships and further evolved into subspecialty residency positions that were supported by Medicare or hospital funds. Hospitals found that subspecialty residents were essential because they could perform a wide variety of procedures and provide both care for hospitalized patients and service to the hospital.

The increased number of subspecialists graduating from university hospital fellowships prompted community hospitals to add subspecialists to their staffs. As these graduates began to care for patients in the same communities served by the university hospitals, the number of patients needing attention at the university hospitals declined, and many university hospitals began to struggle for patient referrals.

Likewise, family practice training programs might also see their clinic patient populations decline in urban areas as their graduates enter practice in nearby communities. Continuous patient care with a stable panel of patients is a basic requirement for family practice training and program accreditation. Although rural tracks are not the only option for providing residents with access to stable patient populations, such programs move residents into settings that can provide equivalent or better training while taking the pressure off urban programs.

Rural Family Physicians and Their Practices Are Well Suited to Prepare Residents for Rural Practice

Academic medical centers that require tenure pressure family practice faculty to develop a research focus, obtain grant support, and publish in peer-reviewed journals. Academic development, however, can come at the expense of maintaining the wide range of clinical skills essential to rural family practice; university-based family practice faculty might drop maternity care, critical care, or procedures common to rural family practice to focus on teaching and research in a limited area. These limitations can result in fewer comprehensive practice role models for residents interested in rural practice, where a broad set of clinical practice skills is needed (maternity care, emergency care, care of adults, care of the elderly, care of children and adolescents).

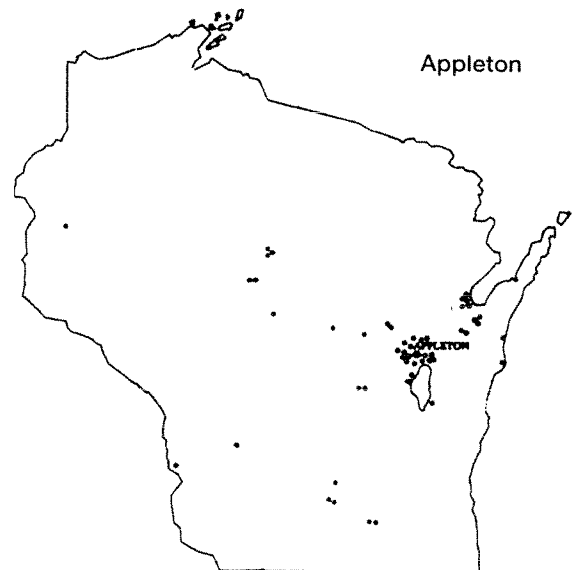
Observing rural physicians successfully provide maternity care can be a great encouragement to residents. In a 1991 survey, University of Wisconsin family practice graduates suggested that to keep maternity care a strong part of family practice, residents should be ensured the positive experience of working with skilled, confident family physician role models.[26] Graduates recommended avoiding training by nonsupportive obstetricians, even if it meant training in a community outside the program where family physicians routinely provide maternity care and work collaboratively with obstetricians.

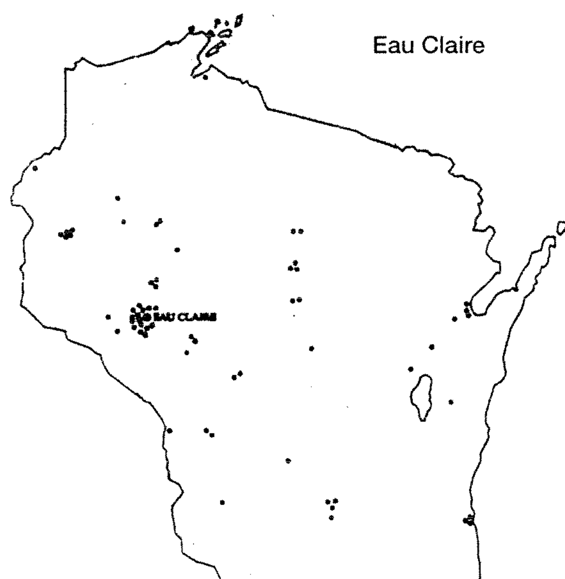
Smith and Howard[27] reported that factors positively associated with providing maternity care were (1) practicing in a rural community and (2)

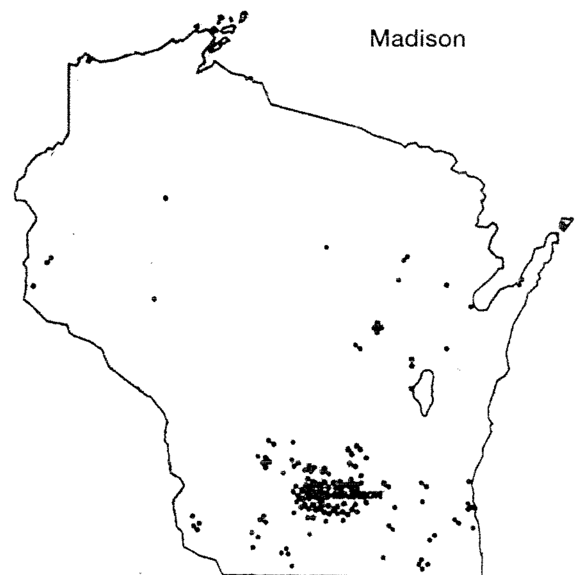
Figure 1. Locations of University of Wisconsin family practice residency graduates (1973-1996) practicing in Wisconsin.

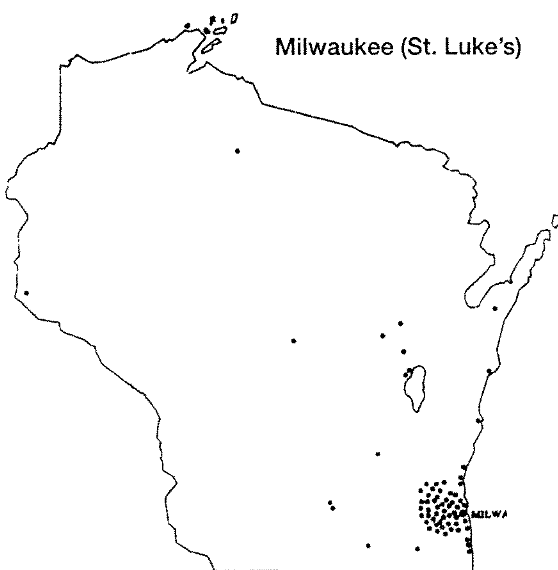
Program	Total Graduates No.	Graduates in Wisconsin* No.(%)
Appleton	87	53 (61)
Eau Claire	109	68 (62)
Madison	289	149 (52)
Milwaukee	129	73 (57)
Wausau	88	57 (65)

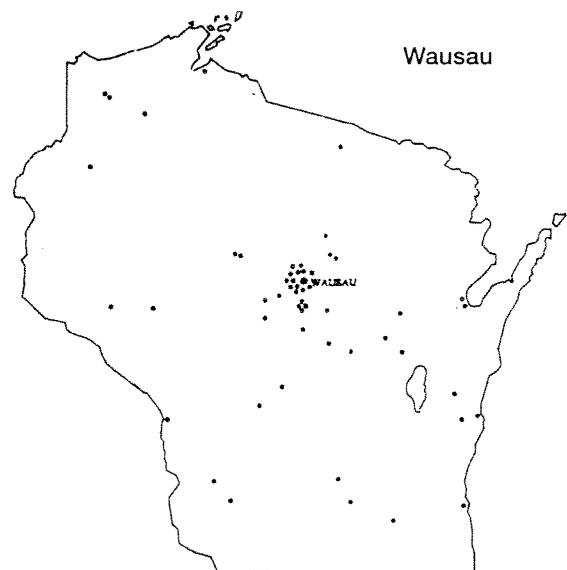
*Confirmed number, 10-15% might be lost to follow-up.
Note: each dot = 1 graduate.











being exposed to good family physician role models during training; they found that graduates who felt inadequately trained in maternity care chose not to provide maternity care and were more likely to go into urban practices. The nursing literature is replete with the value of mentors as role models in training.[28,29] A national survey by Sakornbut and Dickinson[30] illustrated that supervision of obstetric care by family practice faculty increased three- to four-fold the likelihood that family practice residents will choose to do obstetrics.

The lack of immediate on-site specialty backup in rural areas should be seen as a challenge rather than as a threat to the aspiring rural family physician. In larger urban teaching centers, an abundance of subspecialists are available for immediate consultation for neonatal resuscitation, delivery room emergencies, and trauma and cardiac emergencies. In some cities, family practice residents are told by subspecialists and even by some academic family physician teachers that they should not be performing certain procedures common to rural practice. Because referral is the accepted standard of care in university settings, family physician faculty might be more likely to refer patients who would normally be cared for by family physicians in rural settings. As a result, urban family practice residents can learn a sense of helplessness when encountering delivery room emergencies (retained placenta, postpartum hemorrhage, instrument delivery) and neonatal emergencies (resuscitation, sepsis evaluation, hypoglycemia, tachypnea) and miss the opportunity to acquire the breadth of skills needed in rural practice.

Other rapidly evolving changes in urban health care systems further highlight differences in urban and rural practice. In some large university programs, the combination of managed care, numerous clinical sites, heavy reliance on Medicare funds passed through hospitals, and multiple duties of academic faculty require complex, multiclinic after-hours call systems quite different from systems encountered in rural practice. The evolution of a hospitalist model, in which family physicians care for outpatients and subspecialists care for inpatients, is also gaining momentum in some larger urban areas. How will family physicians receive training relevant to rural family practice if changes such as these become the norm?

Our rural family physician colleagues and the environment in which they practice can be much better positioned to serve the family practice resident interested in a rural career.

Rural Training Tracks Offer Advantages for Residents, Academic Faculty, and Rural Physicians

Family practice residents are exposed to many advantages when they receive training in a rural community. Fewer primary care residents and very likely no subspecialty residents compete for patient care experience. Faculty role models perform procedures common to rural practice. Residents can experience being part of a community where all members of a family seek care from the family physician for most of their health care needs. For residents considering rural practice, this type of preparation is vital. For those who ultimately choose urban practice, the experience will be no less valuable because it exposes the resident to the essence of family practice.

The nonclinical aspects of training in a rural community can also be enlightening. Residents can participate in community activities and experience the effects of their medical practice as they interact with patients as neighbors and citizens. A resident's spouse and family members can experience rural life first hand.

Students applying to the University of Wisconsin family practice rural training tracks say they look forward to a great deal of experiential learning, believe they will receive more personalized teaching, and sense they will be welcomed and needed by the rural practice. Students realize that to achieve these benefits, they must be committed to living in the rural area for the last 2 years of their training.

Rural physicians gain the following benefits from rural training tracks: (1) clinical assistance in their practice, (2) increased career satisfaction, (3) improved image both locally and at the academic medical center, (4) increased collaborative linkages to academic medical centers, and (5) increased attractiveness of the practice to physicians being recruited.

Rural training builds relations between academic and rural physicians that can benefit all parties. Rural physicians can learn teaching skills from experienced academic family physician teachers through faculty development programs. Academic family physicians can broaden their horizons by observing clinicians skilled in rural medicine practice case management. Town-gown

rivalries that might exist can be bridged by having urban and rural physicians work together on educational ventures to improve access to health care in rural communities.

Rural Training Track Weaknesses

Despite many good arguments for developing rural training tracks, there are drawbacks. Administrative and teaching time, program cost, practice volatility, distance, isolation, quality, and accreditation requirements are serious concerns. Many programs (and rural clinics) interested in developing a rural track have neither the time nor the staff for the enormous amount of preplanning required to prepare the site, write the accreditation documents, negotiate affiliation agreements, facilitate site visits by the American College of Graduate Medical Education (ACGME), write recruitment materials, and train the rural faculty. It could be difficult to recruit and maintain the number of residents required by the ACGME—at least 2 residents per site, 1 second-year resident and 1 third-year resident—to increase collegial support.

Smaller training sites are also more vulnerable to staff changes. Should one or more physicians leave the practice suddenly, inadequate teaching time could result as the remaining physicians struggle to care for the patients who visit the clinic. What should be a positive experience could turn out to be negative for residents if they work with exhausted, stressed role models. Distances that need to be traveled by residents pose driving dangers and weather hazards. Residents can feel isolated from the colleagues they trained with during their first year. The quality of education residents receive in rural tracks might be questioned until sufficient learning outcomes research shows the effectiveness of this educational model. Such problems are not unique to rural tracks, but they might have to be addressed differently than they are in the larger urban programs.

Rural Tracks Alone Will Not Solve Rural Physician Shortages

Many additional changes in the health care system are necessary to enhance rural health. Typically, Medicare pays health maintenance organizations 18 percent more to care for urban enrollees compared with rural enrollees.[31] Medicare must recognize the contributions of rural providers and compensate them equally. The American College of Physicians has recommended remote access telecommunication and innovative delivery systems to improve access to and delivery of primary care in rural areas.[32]

Finally, it is up to the rural medical communities that remain underserved at the end of the 20th century to persuade graduates to consider staying in rural areas, find satisfying practices, and provide the services needed. Rural physicians must contribute to collegial partnerships with academic physicians, teach clinical skills, and share their enthusiasm for rural practice. Community members must help residents integrate into the social community.

Conclusions

Academic and practicing family physicians must work together to correct physician maldistribution and assure access to medical care in rural areas. There is beginning evidence to suggest that rural training tracks are able to produce graduates who enter rural practice. A recent survey by Rosenthal et al[33] showed that 76 percent of graduates of one-two rural residency tracks entered rural practice after graduation. Further studies are needed to determine whether rural track residents are as well prepared as their core program colleagues and whether rural training tracks are an equivalent or preferred method of preparing residents for rural practice. Broad qualitative studies can measure the costs and effects of rural training on community physicians, community hospitals, and the community itself. If evaluation results show that the effort is worth the outcome, traditional models of residency training should be modified to include more rural training options.

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