Committee Name:
Joint Committee on Finance – Budget Hearings (JCF_BH)

Appointments

99hr_JCF_BH_Appoint_pt00

Clearinghouse Rules

99hr_JCF_BH_CRule_99–

Committee Hearings

99hr_JCF_BH_CH_pt00

Committee Reports

99hr_JCF_BH_CR_pt00

Executive Sessions

99hr_JCF_BH_ES_pt00

Hearing Records

99hr_ab0000

99hr_sb0000

Misc.

99hr_JCF_BH__Misc_Health_pt06

Record of Committee Proceedings

99hr_JCF_BH_RCP_pt00

A.H.E.C

Wisconsin AHEC

STATE REPRESENTATIVE

DAVID WARD

37th Assembly District

The attached is provided
for your information.
Please let me know if I can be
of further assistance.

I have attached the testimony from two of my constituents, Sherry Quamme and Diane Veith, as well as that of the Community Bankers of Wisconsin. None of them were able to testify at the public hearing in Madison; however, they asked me to be sure their testimony was still included in the record. Thanks, Dave

---

P.O. Box 8953, Madison, WI 53708

(608) 266-3790

April 15, 1999
Judiciary Hearing
Madison WI

Sherry Quamme
Associate Administrator
Patient Care Services
Columbus Community Hospital, Inc.
1515 Park Ave.
Columbus WI 53925
(920) 623-2200

Wisconsin AHEC System
Chair, Board of Directors

RE: **Speaking in Favor of $700,000 Increase In Funding For The Wisconsin AHEC System**

What is AHEC? What does AHEC do?

The Wisconsin Area Health Education System, or AHEC, aims to improve the distribution, supply, quality, utilization and efficiency of health personnel in rural and underserved communities in Wisconsin.

The WI AHEC is administered through the UW Medical School. The work of AHEC is done through four regional, community-based organizations.

Local AHEC's act to join together the resources of the UW Medical School with communities that have a health related need.

How has AHEC Impacted Columbus and Columbus Community Hospital?

- Placement of medical students and selected family practice residents at our rural hospital. Dr. Mary Davis was a family practice resident at our hospital and is now a family practice physician living and working in our community. Her presence has been instrumental in recruiting other physicians. Medical students continue to have rotations to our rural site.
- Senior nursing students have a semester of clinical nursing experience at our rural hospital. 7 of these students have chosen to accept employment at our hospital because of these rotations. They would not have considered us without this AHEC supported program.
- Physical Therapy students from UW Madison, UW LaCrosse and Carroll College utilize our hospital through AHEC supported clinical rotations. Physical Therapy Assistant students from Blackhawk Technical College in Janesville receive training at our hospital and we were successful in employing a student in a position that was open for two years prior the start of this clinical rotation.
- Occupational Therapy students also have clinicals at our hospital.

- These are professionals in growing shortage that are recruited because of the clinicals they have at our rural site. Without the clinicals, they wouldn't give us a second thought.
- High School Students take Certified Nursing Assistant courses supported by AHEC programs in partnership with the hospital and local nursing home. The students then have exposure to a health occupation plus a way to earn income to help support their college education.

Other AHEC Benefits To My Community and Area:

- Facilitated continuing education opportunites
- Functioned as a convener and facilitator to address health care access or workforce needs. Example: Nurse Practitioner student clinical that resulted in employment for two Nurse Practitioners in separate physician clinics.
- Provided training and technical assistance for accessing computer-based health information and library resources. Located a PC workstation in a physician clinic for use by nurse practioner students, medical students. Available for nursing and physical therapy students.
- Through timely access to health information, have been able to improve patient care.
- Provided technical assistance for community health improvement projects.

What Does Columbus Community Hospital and Wisconsin Need AHEC for in the Future? How will Wisconsin be Impacted If There Is A Loss of Funding?

- Expansion of medical and health professional education in rural and underserved communities like Columbus. We are facing a severe health professions shortage. Students who have clinical experiences at rural and underserved sites give consideration to practicing at those sites. There is a network of systems across Wisconsin now supported by faculty from the University of Wisconsin, our techical colleges, many of our private colleges and a host of community health care providers. AHEC has nurtured and created this. It will be lost if the funding is lost.
- Coordination of community-based activities across regions
- Decreased communication among health professional training programs and community providers would be an outcome of decreased funding. These are the volunteer preceptors of the students. AHEC provides distance learning, technology communication access and continuing education along with health care services support. (Farm health accessments at Feed Mills, Migrant worker health services, dental care access in Wautoma for underserved, South Madison Health Clinic services and others.) Programs would close, cease to exist.
- Without some increase in funding, regional AHEC centers will have to cut programs and services and, maybe even close.

Relevant Facts & Figures To Consider:

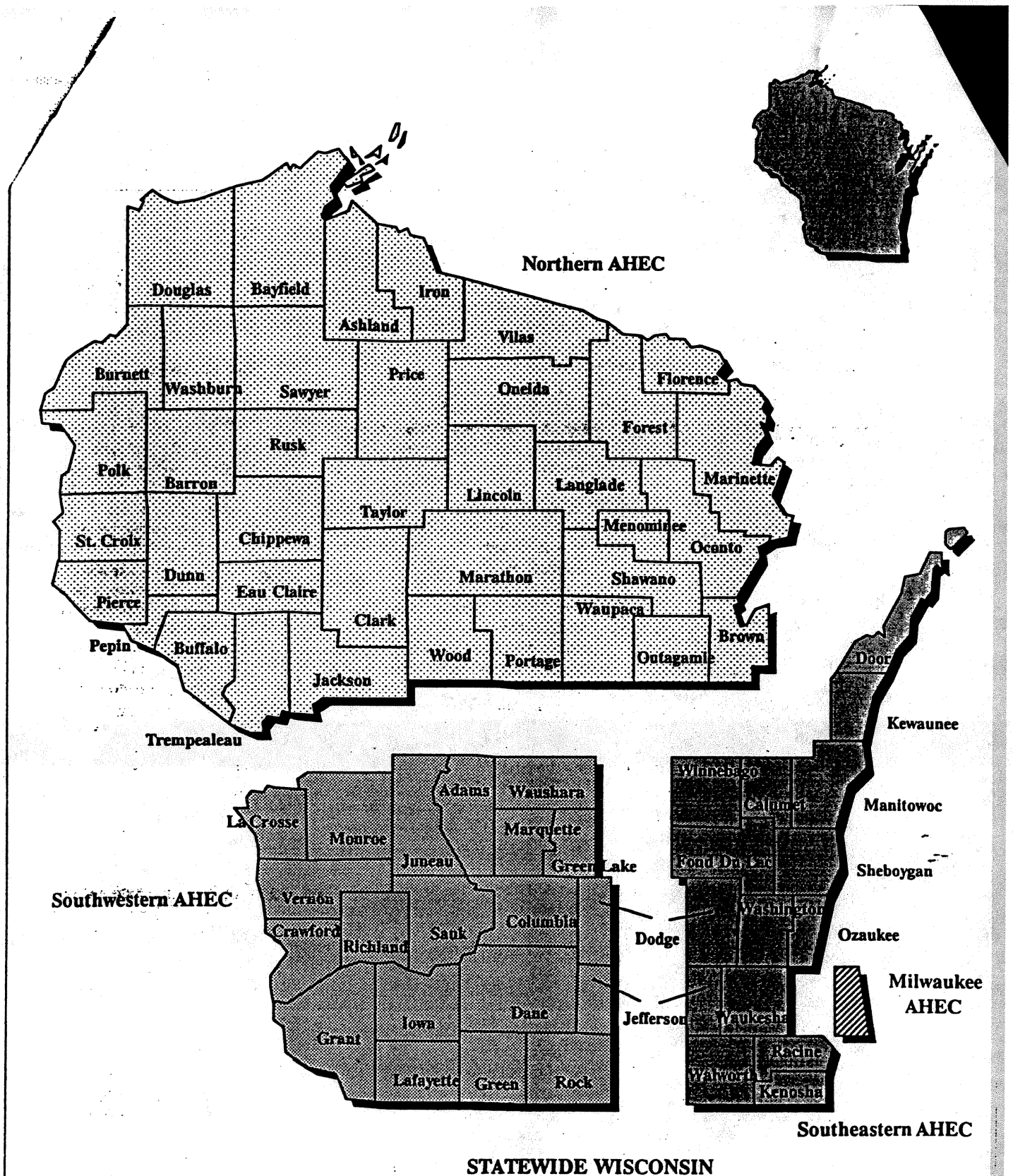
- Wisconsin AHEC System is requesting total state funding of $1.5 million per year to maintain current programs and services.
- Current AHEC System budget is $1.56 million per year

$763,000 in federal money
$800,000 in state funds

- Federal money is ending September 30, 1999
- Request:
  Maintain $800,000 per year appropriation in Govenor's budget
  Increase of $700,000 per year in state funds, please

Please understand the need to support the Wisconsin AHEC System through the increase of $700,000 per year to continue to statewide and regional, community based AHEC programs and projects that result in better health care services to rural and underserved populations of our state.

Thank you to all committee members for your attention to the health related needs of rural and underserved areas of Wisconsin.



STATEWIDE WISCONSIN AHEC AREAS

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:

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.

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.

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).

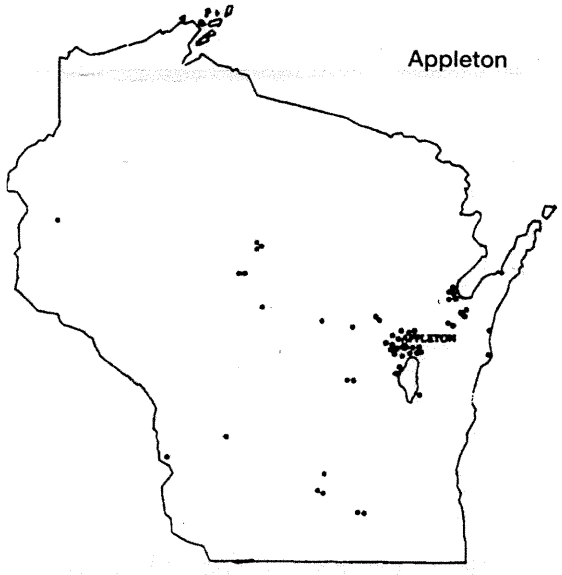
Observing rural physicians successfully provide maternity care can be a great encouragement to residents. In a 1991 survey, University of Wisconsin family practice graduates suggested that to keep maternity care a strong part of family practice, residents should be ensured the positive experience of 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.

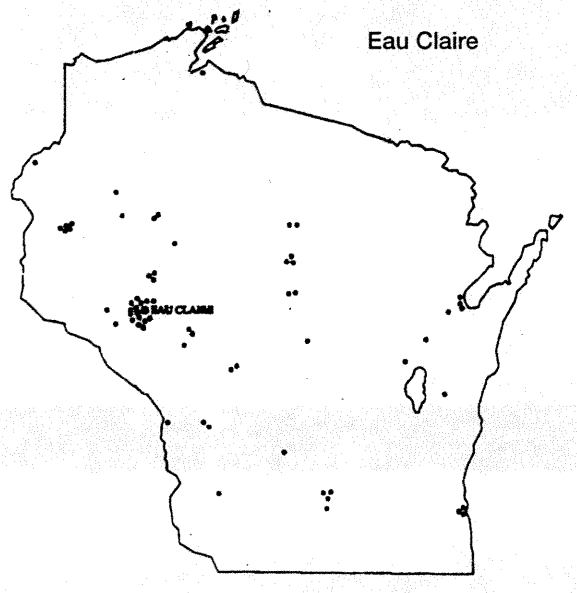
Smith and Howard[27] reported that factors positively associated with providing maternity care were (1) practicing in a rural community and (2)

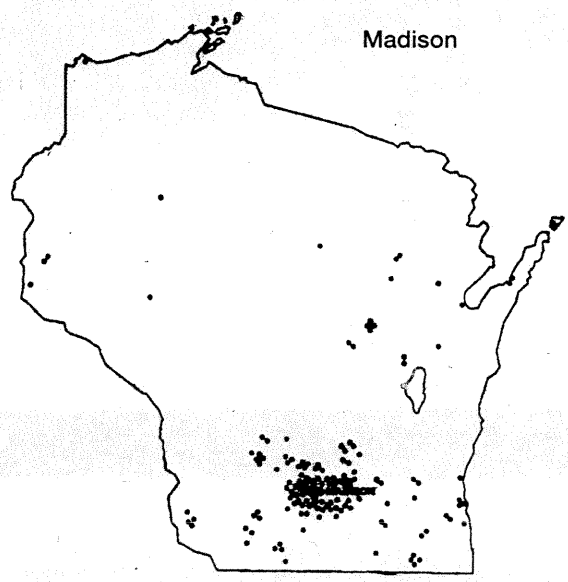
Figure 1. Locations of University of Wisconsin family practice residency graduates (1973-1996) practicing in Wisconsin.

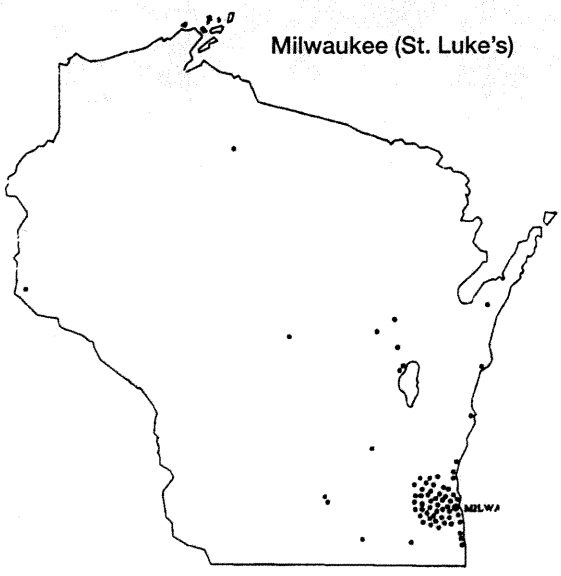
Program	Total Graduates No.	Graduates in Wisconsin* No.(%)
Appleton	87	53 (61)
Eau Claire	109	68 (62)
Madison	289	149 (52)
Milwaukee	129	73 (57)
Wausau	88	57 (65)

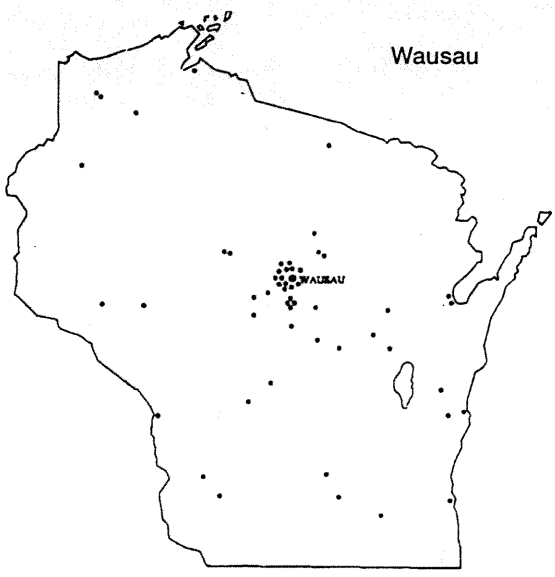
*Confirmed number, 10-15% might be lost to follow-up.
Note: each dot = 1 graduate.











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.

References

1. Program information form for residencies in family practice. Chicago: Accreditation Council for Graduate Medical Education, 1997:iii.
2. Rosenthal TC, Maudlin RK, Sitorius M, Florence JA, Markowski G, Cleveland PD, et al. Rural training tracks in four family practice residencies. Acad Med 1992;67:685-91.
3. Damos JR, Sanner LA, Christman C, Aronson J, Larson S. A process for developing a rural training track. Fam Med 1998;30:94-9.
4. Dalen JE, editor. US physician manpower needs: generalists and specialists: achieving the balance. Arch Intern Med 1996;156:21-24.
5. STFM Group on Rural Health. Concerns raised re-

garding graduate locations. Am Fam Physician Newslett, Summer 1997.

6. Kindig DA, Movassaghi H. The adequacy of physician supply in small rural counties. Health Aff Millwood 1989;8(2):63-76.
7. Institute of Medicine. Medical professional liability and the delivery of obstetric care. Washington, DC: National Academy of Press, 1989.
8. Larimore WL. Pregnancy care liability misperceptions among medical students in Florida. Fam Med 1994;26:154-6.
9. Greenberg DM, Hochheiser LI. Family practice residents' decision making regarding future practice of obstetrics. J Am Board Fam Pract 1994;7:25-30.
10. Nesbitt TS, Arevalo JA, Tanji JL, Morgan WA, Aved B. Will family physicians really return to obstetrics if malpractice insurance premiums decline? J Am Board Fam Pract 1992;5:413-8.
11. Nesbitt TS, Kahn NB, Tanji JL, Scherger JE. Factors influencing family physicians to continue providing obstetric care. West J Med 1992;157:44-7.
12. Larimore WL, Davis A. Relation of infant mortality to the availability of maternity care in rural Florida. J Am Board Fam Pract 1995;8:392-9.
13. Allen DI, Kamradt JM. Relationship of infant mortality to the availability of obstetrical care in Indiana. J Fam Pract 1991;33:609-13.
14. Nesbitt TS, Connel FA, Hart LG, Rosenblatt RA. Access to obstetric care in rural areas: effect on birth outcomes. Am J Public Health 1990;80:814-8.
15. Clifford WB, Lilley SC. Rural elderly: their demographic characteristics. In: Bull CN. Aging in rural America. Focus Editions Ser Vol 162. Newbury Park, Calif: Sage Publications, 1993:3-20.
16. Fuguitt GV, Beale CL. The changing concentration of the older nonmetropolitan population, 1960-90. J Gerontol 1993;48:S278-88.
17. Zedlewski SR, Narnes RO, Burt MK, McBride TD, Meyer J. The needs of the elderly in the 21st century. Washington, DC: The Urban Institute, 1989.
18. Doty PJ. The oldest old and the use of institutional long term care from an international perspective. In: Suzman RM, Willis DP, Manton KG, editors. The oldest old. New York: Oxford University Press, 1992:251-67.
19. Besdine RW, Rubenstein LZ, Snyder L, editors. Medical care of the nursing home resident: what physicians need to know. Philadelphia, American College of Physicians, 1996:xiii.
20. Bowman RC, Penrod JD. Family practice residency programs and the graduation of rural family physicians. Fam Med 1998;30:288-92.
21. Mangus JH, Tollan A. Rural doctor recruitment: does medical education in rural districts recruit doctors to rural areas? Med Educ 1993;27:250-3.
22. Lebel D, Hogg W. Effect of location on family medicine residents' training. Can Fam Physician 1993; 39:1066-9.
23. LeFevre ML, Colwill JM. Practice location as a function of medical school and residency location: implications for resident selection. J Fam Pract 1983;16:1157-60.
24. Bowman RC. Continuing family medicine's unique contribution to rural health care. Am Fam Physician 1996;54:471-4, 479, 483.
25. Dalen JE. US physician manpower needs. Generalists and specialists: achieving the balance. Arch Intern Med 1996;156:21-4.
26. Turkal N, Christman C. Graduates' comment on issues related to the decline of Wisconsin family physicians providing maternity care. Wis Med J 1996;95:17-21.
27. Smith MA, Howard KP: Choosing to do obstetrics in practice: factors affecting the decisions of third-year family practice residents. Fam Med 1987;19:191-4.
28. Hayes E. Helping preceptors mentor the next generation of nurse practitioners. Nurse Pract 1994; 19(6):62-6.
29. Taylor LJ. A survey of mentor relationships in academe. J Prof Nurs 1992;8(1):48-55.
30. Sakornbut EL, Dickinson L. Obstetric care in family practice residencies: a national survey. J Am Board Fam Pract 1993;6:379-84.
31. United States, Prospective Payment Assessment Commission. Medicare and the American health care system: report to the Congress. Medicare and Medicaid guide, issue no 964, no 960, part 2. Washington DC: The Commission, 1997.
32. Rural primary care. American College of Physicians. Ann Intern Med 1995;122:380-90.
33. Rosenthal TC, McGuigan MH, Osborne J, Holden DM, Parsons MA. One-two residency tracks in family practice: are they getting the job done? Fam Med 1998;30:90-3.

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????

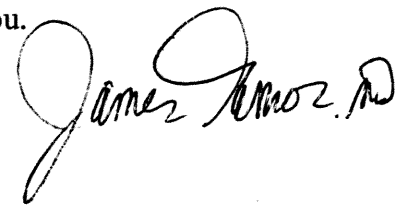
   a. Since these programs are just developing now, AHEC is seeking an additional $700,000 in state funding for each year of the next biennium in order to maintain its programmatic initiatives in underserved areas around the state.

   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.



NAMI Wisconsin

April 12, 1999

Dear Member of the Joint Finance Committee
Wisconsin State Legislature

I am testifying before you regarding the proposed budget cut in funding for the Blue Ribbon Commission On Mental Health Demonstration Projects over the next biennium. This drastic reduction from eight to two demonstration projects will seriously affect the ability of the DHFS to test and pilot the carefully crafted reforms of the Blue Ribbon Commission (BRC).

The effort of the many task committees and work groups that are implementing the BRC recommendations has been progressing for nearly two years and is nearly finished. The work product of the many consumers, advocates, state administrators, local county representatives, professionals and consultants is ready for the contracting process. The BRC was given the task by the governor to reform the public mental health system.

The new system will use managed care techniques to provide community based, outcome driven, consumer and family oriented services with greater flexibility. The planning process has utilized the experience, both positive and negative gained by similar programs nation-wide.

The Governor received the BRC report with enthusiasm. I feel that the under-funding ($1,170,000 requested vs. $290,000 provided in the budget bill) of the demonstration pilots is a serious blow to the the research and analytic effort that was to have made this project an example of Wisconsin's leadership in the mental health field. The under-funding is a slap-in-the-face to the people who have participated in this entire program and would thwart the effort to test out a number of pioneering methods for mental health care delivery to ascertain the most effective strategies.

I urge you to restore the budget cuts and allow this innovative and carefully planned process to reach its goals. This has been a once-in-twenty -year project which deserves to be implemented with sufficient resources to accomplish its goal in a reasonable time frame.

Sincerely,

Robert L. Beilman M.D.

Robert L. Beilman, M.D.
Immediate Past President
Wisconsin Alliance for the Mentally Ill (NAMI-WI)

1410 Northport Drive • Madison, WI 53704-2041
Phone: (608) 242-7223 • Toll free: (800) 236-2988 • Fax: (608) 242-7225 • E-mail: amiwisc@aol.com

March of Dimes WalkAmerica®

March of Dimes
Birth Defects Foundation

Capital Wisconsin Chapter
4904 Triangle Street
McFarland, WI 53558-9363
Telephone (608) 838-6649
Toll Free (800) 747-DIME (3463)
Fax (608) 838-6661

Testimony on Funding for Birth Defects Surveillance

Wisconsin Joint Finance Committee - Madison - April 15, 1999

presented by Terry Bucheger, Volunteer

March of Dimes Birth Defects Foundation

My name is Terry Bucheger. I am a volunteer for the March of Dimes Birth Defects Foundation. Thank you for the opportunity to present testimony today on behalf of the March of Dimes in support of increased state funding for a comprehensive birth defects surveillance program in Wisconsin.

The mission of the March of Dimes is to improve the health of babies by preventing birth defects and infant mortality. A comprehensive birth defects surveillance program will improve the health of our babies by counting the number of babies born with defects and pointing to ways we can prevent or treat congenital conditions.

In my professional life, I work with substance-abusing women and their families at the Center for Women and Children here in Madison. Every day I am confronted with the damage done by drugs and alcohol during pregnancy- damage to the baby in the form of Fetal Alcohol Syndrome and quite often lifelong damage to the health of the entire family.

Birth defects are a major health problem, occurring in children of all races, economic classes, and in every part of the state. Birth defects are the leading cause of infant mortality. In Wisconsin, every year, 150 babies die as a result of birth defects. We know this from infant death certificates, but we do not know how many infants are born with and survive a birth defect. We estimate – because we do not really know – that 2,000 Wisconsin babies are born with a birth defect each year.

It is important to note that not all birth defects are readily apparent at birth. In Wisconsin birth defects are reported on birth certificates; however, this method of data collection provides incomplete information. Many conditions are diagnosed months and sometimes years following birth. For example, Fetal Alcohol Affects – a less severe birth defect than Fetal Alcohol Syndrome - may not be detected until a child is two or three years old.

40 other states have initiated birth defects surveillance programs, leaving Wisconsin far behind in this important data collection function. There are model programs that show how surveillance and research can be combined to study the relationship of birth defects to factors such as nutrition, tobacco use, occupational hazards, and toxic substances in the environment. Only a quality state birth defects surveillance system will accurately identify birth defects and provide data that can be used to study causes.

A state birth defects program would provide data needed to investigate the cause of birth defects, assess progress of prevention and evaluate the need for services. Surveillance systems enable health officials to monitor infant health and look for clusters of birth defects. The detection of birth defects should not be left to chance.
Given the high price of birth defects, the cost for a comprehensive birth defects surveillance and research program is small. In the proposed state budget, funding for birth defects surveillance is at $49,500 per year, to fund one full time position. And while we support the proposed change in statutory language, a larger financial investment must be made as well.

It would take $8.00 per birth or about $500,000 per year to make Wisconsin's program the first-class system that our citizens and future generations need. That is an awfully small investment compared to the high cost of medical care and long-term care associated with poor birth outcomes. The volunteers and staff of the March of Dimes look forward to working with you as Wisconsin invests its resources to prevent birth defects.

Thank You

April 15, 1999
~~Judiciary Hearing~~ Joint Finance Comm.
Madison WI

Sherry Quamme
Associate Administrator
Patient Care Services
Columbus Community Hospital, Inc.
1515 Park Ave.
Columbus WI 53925
(920) 623-2200

Wisconsin AHEC System
Chair, Board of Directors

RE: **Speaking in Favor of $700,000 Increase In Funding For The Wisconsin AHEC System**

What is AHEC? What does AHEC do?
The Wisconsin Area Health Education System, or AHEC, aims to improve the distribution, supply, quality, utilization and efficiency of health personnel in rural and underserved communities in Wisconsin.

The WI AHEC is administered through the UW Medical School. The work of AHEC is done through four regional, community-based organizations.

Local AHEC's act to join together the resources of the UW Medical School with communities that have a health related need.

How has AHEC Impacted Columbus and Columbus Community Hospital?

- Placement of medical students and selected family practice residents at our rural hospital. Dr. Mary Davis was a family practice resident at our hospital and is now a family practice physician living and working in our community. Her presence has been instrumental in recruiting other physicians. Medical students continue to have rotations to our rural site.
- Senior nursing students have a semester of clinical nursing experience at our rural hospital. 7 of these students have chosen to accept employment at our hospital because of these rotations. They would not have considered us without this AHEC supported program.
- Physical Therapy students from UW Madison, UW LaCrosse and Carroll College utilize our hospital through AHEC supported clinical rotations. Physical Therapy Assistant students from Blackhawk Technical College in Janesville receive training at our hospital and we were successful in employing a student in a position that was open for two years prior the start of this clinical rotation.
- Occupational Therapy students also have clinicals at our hospital.

- These are professionals in growing shortage that are recruited because of the clinicals they have at our rural site. Without the clinicals, they wouldn't give us a second thought.
- High School Students take Certified Nursing Assistant courses supported by AHEC programs in partnership with the hospital and local nursing home. The students then have exposure to a health occupation plus a way to earn income to help support their college education.

Other AHEC Benefits To My Community and Area:

- Facilitated continuing education opportunites
- Functioned as a convener and facilitator to address health care access or workforce needs. Example: Nurse Practitioner student clinical that resulted in employment for two Nurse Practitioners in separate physician clinics.
- Provided training and technical assistance for accessing computer-based health information and library resources. Located a PC workstation in a physician clinic for use by nurse practioner students, medical students. Available for nursing and physical therapy students.
- Through timely access to health information, have been able to improve patient care.
- Provided technical assistance for community health improvement projects.

What Does Columbus Community Hospital and Wisconsin Need AHEC for in the Future? How will Wisconsin be Impacted If There Is A Loss of Funding?

- Expansion of medical and health professional education in rural and underserved communities like Columbus. We are facing a severe health professions shortage. Students who have clinical experiences at rural and underserved sites give consideration to practicing at those sites. There is a network of systems across Wisconsin now supported by faculty from the University of Wisconsin, our techical colleges, many of our private colleges and a host of community health care providers. AHEC has nurtured and created this. It will be lost if the funding is lost.
- Coordination of community-based activities across regions
- Decreased communication among health professional training programs and community providers would be an outcome of decreased funding. These are the volunteer preceptors of the students. AHEC provides distance learning, technology communication access and continuing education along with health care services support. (Farm health accessments at Feed Mills, Migrant worker health services, dental care access in Wautoma for underserved, South Madison Health Clinic services and others.) Programs would close, cease to exist.
- Without some increase in funding, regional AHEC centers will have to cut programs and services and, maybe even close.

Relevant Facts & Figures To Consider:

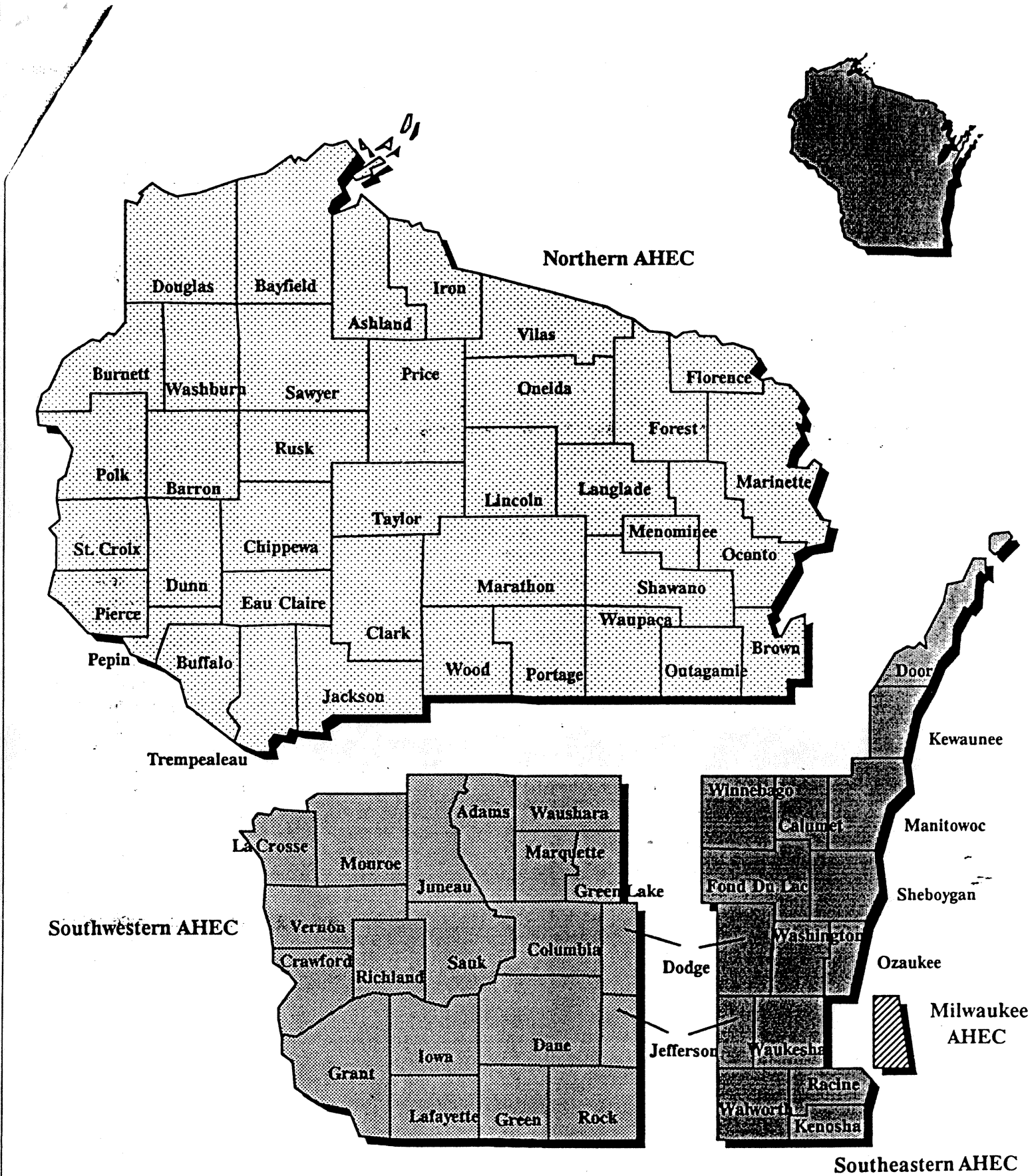
- Wisconsin AHEC System is requesting total state funding of $1.5 million per year to maintain current programs and services.
- Current AHEC System budget is $1.56 million per year

$763,000 in federal money
$800,000 in state funds

- Federal money is ending September 30, 1999
- Request:
  Maintain $800,000 per year appropriation in Govenor's budget
  Increase of $700,000 per year in state funds, please

Please understand the need to support the Wisconsin AHEC System through the increase of $700,000 per year to continue to statewide and regional, community based AHEC programs and projects that result in better health care services to rural and underserved populations of our state.

Thank you to all committee members for your attention to the health related needs of rural and underserved areas of Wisconsin.



STATEWIDE WISCONSIN

AHEC AREAS