HEALTH CARE IN RURAL MINNESOTA

Fewer physicians and challenges ahead—but a commitment to care

BY LINDA PICONE
Rural health isn’t in that great of shape,” says Matthew Bernard, MD, co-founder and medical director for The Center Clinic in Dodge Center and Owatonna. “If we don’t get creative in how to solve the current problem, the problem will worsen.”

Paula Termuhlen, MD, regional campus dean, University of Minnesota Medical School, Duluth Campus, says, “In the northwest quadrant of Minnesota, there’s only one physician for every 1,500 people. In the Twin Cities, it’s one for every 750 people. And the average age of physicians in rural Minnesota is about 55, so you have an aging group.”

Shortages in the number of physicians—and of health care professionals at virtually all levels—are likely not only to continue, but to deepen.

Recruitment

Termuhlen is clear on what it takes to train physicians who will work in rural areas: they need to have a personal connection. “It starts with who we bring in the door,” she says, “people who come from these communities and want to go back to their communities or communities that are similar.”

But rural communities are, in general, shrinking in population. As successful as the training at University of Minnesota Duluth Campus has been, it can’t replace every physician who is ready to retire. For physicians who are not going “home,” there are obstacles to them choosing to work in a rural area.

“The biggest challenge is probably a mixture of the demand they have on them between working clinic, hospital, rounds at the nursing home … being the main provider in the community,” says Mark Jones, executive director, Minnesota Rural Health Association. “And that workload, matched up with the compensation, makes a higher-paying area more attractive.”

Bernard says it’s a challenge to incent medical students to look at the idea of rural practice for exactly the reasons Jones cites. “With student debt and just the difference in salary, if I can make $350,000 vs. $150,000, that’s pretty important. And if I’m interested in primary care and I go to a rural area and people seem to be extremely overworked, I’m going to be reluctant to do that myself.

“When I came out of residency 26 years ago, that was part of the expectation: being on call, clinic, hospitals rounds, delivering babies … It was kind of what I signed up for. Now, people are looking for more of a work-life balance.”

Even those who may like the ability to fish off their own dock at the end of the day, or the sight of the stars unblocked by urban lights, the lack of cultural amenities they are used to and a sense of being isolated from their professional peers can be significant negatives.

“Workforce is a critical issue outstate,” says Nathan Blad, CEO, Renville Hospital and Clinics. “Even more so in areas like Renville County, where we have a large geography but just 10 small communities. A third of our population still live on their

Estimates of physicians per 1,000 residents are based on data from the Minnesota State Demographer’s Office and analysis by the Minnesota Department of Health of information from health licensing boards. Data is from 2015, 2016 and 2017.

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—NATHAN BLAD, CEO, RENVILLE HOSPITAL AND CLINICS
farms. We don’t have all the amenities you would normally highlight to recruit folks. We’ve been fortunate, but as we look to the future, there will be shortages of physicians, nurses, lab technicians, radiologists …”

**Technology**

Some rural clinics and hospitals are already using technology to bridge gaps, provide more services to patients and allow primary care physicians to do what they do best—with the support of specialists.

“Tele-health is an opportunity for the rural physician,” says Jones. “A patient can see a specialist, but never leave the organization the rural physician works for. That makes the primary care physician the hub of their medical care.”

In 2014, Renville Hospital and Clinics was one of the first to launch a tele-cardiology program through Allina, according to Blad. That program has subsequently rolled out to several other organizations. Renville also uses Avera Health in Sioux Falls for tele-emergency care. “In rural areas, you have great trained providers, but they don’t always see every kind of emergency in a small shop,” says Blad. “It’s nice to be able to push a button and get a board-certified emergency physician in Sioux Falls looking at the patient.”

Renville Hospital and Clinics has launched a tele-neurology clinic as part of its tele-stroke clinic through Centracare, in which people who come into the emergency department with a suspected or possible stroke can have all of their follow-up appointments at the clinic in Renville through tele-health.

Being able to message specialists, ICU, tele-dermatology and more will allow physicians—and their patients—to know they have the resources they need when they need them, says Bernard.

“I envision a future where you’re going to have primary care physicians with pretty comprehensive support from most specialties through tele-medicine,” says Terry Hill, senior advisor for rural health leadership and policy, National Rural Health Resource Center in Duluth. “It will allow physicians to do more of what they do best, what they were trained to do.”

A couple of key issues limit how quickly and broadly tele-medicine can be used in rural areas:
- Access to broadband—not every area has good connectivity.
- Payment for services provided electronically is still something of a question mark with many insurers.

**Affiliation/merger**

Affiliation and merger of health care entities is not unique to rural areas; if anything, it may be coming to rural areas later than to the urban cores. “Without some sort of payment reform, I think it’s inevitable that the economies of scale will have to be utilized even heavier,” says Jones.

“Our rural hospitals are barely making it now. The transition of payment based on volume to payment based on value will help, but I just don’t see how the independent hospitals and clinics are going to survive on the reimbursement rates they have today without some kind of help from somewhere else.”

Jones doesn’t see mergers of independent clinics and hospitals as necessarily negative for health care quality: “The push will always be to be better and better, no matter who owns it or how it’s affiliated.”

But people in rural areas tend to look at their hospitals as part of what makes them a real community. “It’s the school and the hospital and the grocery store; everybody supports it,” Jones says.

Renville Hospital and Clinics is being transparent about its exploration of merger or partnering with a larger system: it has published the search on its website. Blad says that after about 18 months of strategic planning, the board looked toward the future and saw significant gaps. “We’re making our budget, but with the way things are changing, we’re going to have to have access to scale, scope, analytics—and we need workforce,” he says. “To fulfill our promise to our community, we need to look to partnership.”

Renville is looking for partnership from a position of strength, Blad says. It sent out a non-binding RFP to see if there are partners willing to work with the organization in the way it would like. He says there are some potential partners and they will have a clearer picture of how things might go by the end of the year.

Partnership or merger is better than the alternative, says Jones: “I would just hate to see closures. We don’t need fewer hospitals—like Texas, Mississippi, Alabama. You close down a hospital and lose 100 jobs in a town of 2,000. That means fewer people

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Reimbursement
The move to reimburse physicians based on value rather than volume can be good news for rural physicians, according to Hill. “It means primary care physicians have much greater value than they have had in the past,” he says. “We’re seeing already that reimbursements for physicians using tele-health and tele-medicine are improving.”

Bernard agrees that reimbursement based on value allows physicians to focus on health and wellness. “Right now, the sicker people get, the more we can do and the more we get paid,” he says. “If we could get credit for keeping people well, that would really change the dynamic.”

Innovation
In everything from patient care to providing community services, rural clinics and hospitals are looking at ways to innovate. Focusing on health and wellness can be an important part of that innovation.

“I would love to talk about wellness all day,” says Blad. Renville Hospital and Clinics created a director of community wellness and outreach position about a year ago. She started her work by touring all 10 communities the hospital and clinic serve and interviewing about 70 people to ask what health and wellness means to them. “It’s a human-centered design approach, to understand what they are looking for, or to articulate what they may not even know they need,” Blad says.

Renville has used that work as part of its strategic planning and as the basis for grant applications. With grant funding, the organization was able to have assist schools and the communities it serves to students who have had Adverse Childhood Experiences (ACE). “If you can help our children deal with those at an early age, there are fewer problems in later years,” Blad says.

Renville joined an accountable care organization a few years ago and Blad says that helped them realize that providing group activities was not enough, that they need to make individual efforts with patients. “It helped our clinic focus—and has actually helped with costs,” he says.

The Center Clinic uses community volunteers to help with people who aren’t culturally or legally comfortable accessing health care, Bernard says. “Volunteer” is an important concept at The Center Clinic—all of the physician and physician assistant time is volunteered. Bernard helped start the clinic about 20 years ago, as a way to provide health care for the underinsured and uninsured. He thought it would also be a good opportunity for residents at Mayo Clinic to care for a different patient population. Grant funding has helped ensure that the clinic’s services are consistent.

A recent grant from the Bremer Foundation has created an exciting challenge for The Center Clinic, Bernard says. “The onus is back on us to say, ‘Okay, let’s see how much more we can do for this community of patients that we serve. What’s it look like to do even more?’”

Hill says when physicians work in teams, they can work to the top of their license. Although teams are more common in urban areas now, he believes it will be increasingly the model in rural areas.

A number of rural hospitals have incorporated nursing homes and more in the hospital/clinic building itself. In Bigfork, Scenic Rivers Health Services has assisted living and even senior apartments as part of the hospital/clinic complex. “They’ve created in Bigfork a very strong model of what hospitals will need to do,” Hill says.

Mercy Hospital in Moose Lake has a 24-hour Wellness Center for the community with relatively low-cost membership fees and everything from personal training to classes to a range of strength and cardio equipment. MM

Linda Picone is editor of Minnesota Medicine.