Now the Real Work Begins

The following is from “The March to Accountable Care Organizations—How Will Rural Fare?” by Clint MacKinney, Keith Mueller & Tim McBride in the Journal of Rural Health, Winter of 2011. Its message is more important now than ever as we hopefully move past government shutdowns and Obamacare computer glitches into the long-term slog of providing “better health, better care at a lower cost.”

What’s Needed—“The march to Accountable Care Organizations (ACOs) is on, and rural providers must keep pace. ACOs are a rapidly developing health care delivery model that links provider payment to delivery design, and then holds providers accountable for both clinical quality and cost control. Different than many Managed Care Organizations, ACOs will be provider-led. Rural provider participation will require collaboration among rural providers and with larger, often urban, health care systems. Although rural opportunities exist to improve care and share in cost savings, rural providers are also at risk from those predatory urban systems that do not adequately value rural community health and vitality. Extensive rural preparation and careful due diligence are required. Rural providers and their communities should proactively prepare for a health care future increasingly requiring interdependence, collaboration, and accountability.”

Overview—“ACOs have become one of the hottest new trends in health care. As a new Medicare payment and health care delivery alternative established by the Patient Protection and Affordable Care Act (ACA), ACOs create opportunities for rural health care providers to improve health care quality and control health care costs in their communities. However, despite new opportunities, a bright future for rural providers is not assured. Rural providers must remain cautious of urban-based policies and large health care system programs that might disadvantage rural health care delivery. But caution has its limits. Rural stakeholders should proactively participate in ACO development discussions during rule making and implementation of the ACA. Rural providers must not be left behind. Rural providers and community leaders should take advantage of the new public policy landscape to design and implement innovative health care delivery systems that serve rural people and places.”

“Rural provider participation in ACOs will require collaboration among rural providers and with larger, often urban, health care systems. Rural providers should strengthen their negotiation capacities by developing rural provider networks, understanding large health system motivations, and adopting best practices in clinical management. Rural communities should generate programs that motivate their populations to achieve and maintain optimum health status. Policy makers should develop rural-relevant ACO-performance measures and provide necessary technical assistance to rural providers and organizations.”

“‘Being a national player’ sounds a lot better than ‘eliminating local competition’.”

“Avoid having your ego so close to your position that when your position falls, your ego goes with it.” - Colin Powell
The purpose of this article is to analyze the potential for ACOs to either benefit or erode local health care services in rural areas:

Best Scenario—Rural health care leadership will creatively and proactively develop health care delivery innovations that serve rural people and places and concurrently ensure the long-term viability of local rural health care providers. Rural providers will develop networks with other rural providers to coordinate services that improve care and control costs. Rural networks then will initiate mutually beneficial collaborations with distant and larger health care systems. Those systems will respond as respectful and sensitive partners. The transition to innovative health care delivery systems will be supported by effective public policy recognizing the value of rural communities and the people within. As a result, current rural/urban health and disability disparities will lessen. Rural people and places will become healthier and more vital.

Intermediate Scenario—Both rural and urban health care providers will approach innovation in a laissez-faire fashion. The priorities of the day (e.g., electronic health record implementation) will preclude health care leaders from creative future planning. Collaborations will develop by chance and necessity, without significant preparation that considers the long-term needs of rural people and places and ensures local access to appropriate health care services in perpetuity. Rural/urban health and disability disparities will persist.

Worst Scenario—Urban health care systems will use their financial strength, leadership experience, market dominance, and policy clout to leverage market share from rural providers. Urban predation will shift patients (and hence payment) out of rural areas to support extensive urban infrastructure investments. An attitude will prevail that dismisses the need for all but the most basic rural health care services. Rural provider shortages will dramatically worsen. Rural hospital services will degrade, and the previously unmerited ‘Band-aid station’ label will become a reality. Rural access to quality health care services will therefore diminish, along with the health of rural people and the vitality of rural places. Rural providers and communities can influence which scenario unfolds, but only if they act now to influence ACO development. Rural inaction will invite urban-based providers and programs to fill the health care delivery system vacuum.”

A Note on Rural Provider Autonomy—“Much of medical management maturation has taken place in urban integrated delivery systems, as identified by case studies from the Commonwealth Fund Commission on a high-performance health system. Consequently, the ACO concept is based primarily on an urban experience. An urban model may not be as feasible with multiple independent ambulatory practices (including rural health clinics and federally qualified health centers) and several smaller hospitals. Furthermore, a unified mission and consistent approach to health care delivery is common in well-established integrated delivery systems, but not among unaligned rural providers. Many integrated delivery systems took decades to develop cost control systems and a unified clinical care culture. The cultural authority to consistently manage organizational and provider behavior is a strong strategic asset to an integrated delivery system and is often underdeveloped or absent in autonomous and isolated rural practice situations.”

“Rural provider practices, already frequently smaller than urban practices due to lower population density and greater geographic separation, are likely to be particularly disadvantaged in a system that requires practice redesign, care coordination, and provider collaboration. Rural providers must begin to acknowledge that strict independence is no longer a success strategy. However, and importantly, collaboration does not imply dependence or subservience.”
“And integration is not necessarily synonymous with ownership. Rural providers who wish to negotiate with larger or urban systems must do so from a position of financial, quality, and service strength. Negotiation strength also requires numbers. Therefore, autonomous and disparate rural providers must begin dialogues that lead to rural collaborations. Primary care physicians, specialists, and hospitals must work together not only to negotiate effectively with larger systems, but more importantly to coordinate care, improve quality, and control costs.”

“Enthusiastic provider participation in an ACO will depend on both financial incentives and practice management requirements. Thus, rural leaders must learn how to effectively allocate provider payments and disseminate health management strategies among diverse providers. And finally, the collaborative mentality must extend to individual providers. Atul Gawande tells us that ‘we’ve celebrated cowboys, but what we need is more pit crews. There’s still a lot of silo mentality in health care—the mentality of ‘That’s not my problem; someone else will take care of it’—and that’s very dangerous. But the fact is, it’s teams and, often, great organizations that make for great care, not just great individuals.’”

Frustrating Time to be in Washington

By Congressman Reid Ribble, serving the residents of the 8th Congressional District of Wisconsin:

Government shutdowns, near-defaults on our national debt, and political brinkmanship seem to be dominating the news cycles recently. Unfortunately, those crises don’t tell the full story.

While I see much of Washington’s dysfunction around me every day, there are snippets of functionality breaking through even in today’s House of Representatives. You just have to find them.

Nearly every morning during the government shutdown, several dozen bipartisan lawmakers got together wherever we could find a space to seek a way out of the mess. For those two weeks, we were the largest bipartisan game in town.

While those meetings unfortunately did not garner viable legislation to end the shutdown, we did begin to build and craft something that hasn’t been seen in Washington in a long time—a functioning process of discussion.

From those meetings we were building bonds of trust that we know will serve us well today and in the battles ahead. The more we meet and talk with each other, the more we get to know each other—and the more we find overlapping areas where we can work together for the betterment of our constituents.

One of the more recent examples of bipartisan work that I was a part of was working for Critical Access Hospitals across Wisconsin and the nation. Critical Access Hospitals primarily service rural areas and have been targeted recently for cuts under Medicare reimbursement rates. These cuts would limit access for health care for seniors in rural areas, actually making health care more expensive. Roughly 80 House members—including all eight members of the Wisconsin delegation—came together to prevent these cuts from moving forward and I was proud to be part of that effort.

These types of commonsense initiatives are more common than you might think, but there are still not enough of them. There should be more of these actions on an ongoing basis, and members of Congress should seek those solutions. Unfortunately, it’s always politically easier to blame the other side of the aisle for America’s problems. But a functioning government requires hard work and poll after poll says the American people expect their elected officials to work together to solve problems. They want their Congress to function and do its job.

We’ve entered a period of great unease for our country. Interest rates are starting to tick up, while the economy and consumer confidence are still sluggish. Millions of Americans are still out of work.
When we’re unable to keep our own government functioning, how can those around the globe look to us for leadership on the international stage?

History has shown us that divided government can have great success when attempting to tackle the nation’s problems. President Ronald Reagan worked with Democratic Speaker Tip O’Neill to save Social Security from collapsing. Republican Speaker Newt Gingrich reformed our nation’s welfare system with President Bill Clinton, putting Americans back to work and creating prosperity for millions.

I will continue to work to build trust amongst my House Democratic and Republican colleagues. I believe Congress can still accomplish great things. We just need to make sure we work at it.

**WI Improving but Less Quickly than Others**

The *Health of Wisconsin Report Card* measures the state’s progress towards meeting two overarching goals of the *Healthiest Wisconsin 2020 State Health Plan*: to improve health for all and to eliminate health disparities. The complete report for 2013 is available at: [http://ow.ly/rFXBX](http://ow.ly/rFXBX).

“Wisconsin’s overall grade for health (measured by death rates and self-reported unhealthy days) is a B-, but many subgroups, particularly infant boys, older men, people living in rural areas and in Milwaukee County, Native Americans, and African Americans fare much worse than the state averages on various measures. Because of these large gaps between the healthiest and least healthy subgroups in our state, the Report Card gives Wisconsin a D for health disparities.”

“As part of its mission to translate research for policy and practice, the University of Wisconsin Population Health Institute has prepared the *Health of Wisconsin Report Card* to provide Wisconsin’s residents with an assessment of the state’s health. The first *Health of Wisconsin Report Card* was released in 2007. An updated version was prepared in 2010. Wisconsin’s grade for overall health has remained the same since 2007—a B-. The health disparities grade of D in 2013 is a reflection that Wisconsin could be doing more to reduce health disparities. As with the previous versions, the *Health of Wisconsin Report Card 2013* continues to draw attention to the weaknesses of our current efforts to promote the health of all Wisconsin residents.”

“Wisconsin has improved the overall death rate for every age group examined in the report and has also made improvements in health-related quality of life. However, since Wisconsin is not improving faster than other states, its grades remain the same. There has also been some notable improvement in death rates for many subgroups, including African American and Native American infants, children and young adults. But, there is more to be done to reduce the persistent disparities between vulnerable and less vulnerable residents of our state. The findings from this report are a call to action for the state to work on improving health for all residents. Engaging people in all Wisconsin communities, and across all health, political, and economic sectors within the state will be necessary to improve health for all and reduce the disparities in health outcomes experienced by many.”

*Strategies to improve health can be found at [http://whatworksforhealth.wisc.edu/](http://whatworksforhealth.wisc.edu/) and encourages community members and statewide leaders alike to use the Report Card as a call to action to improve health for all across the state.*
Adams Fights to Decrease Cancer Death Rate

“When Adams County health care leaders learned their county’s cancer death rate was 25.3% higher than the state average, they knew they needed to take action. Two years later their efforts have received statewide recognition and have resulted in over $500,000 in grant funded programs.”

‘The shocking statistics we received in 2011 opened up the discussion about cancer as a public health issue in Adams County,’ said Sarah Grosshuesch, Adams County Public Health Officer. ‘Local leaders agreed it was time for a coordinated plan to address this issue.’”

The statistics came from an assessment conducted by the University of Wisconsin Carbone Cancer Center. Following the assessment, UW Carbone reached out to Adams County’s Public Health, Aging Department, UW Extension and Moundview Memorial Hospital to form the first of its kind academic-rural partnership in southern Wisconsin.”

The coalition, named Adams County Cancer Awareness Team (ACCAT), launched a pilot project in 2011 called ‘Cancer Clear and Simple’ to address cancer prevention, screening and survivor rates. The program includes facilitated presentations and handouts on cancer that are tailor-made to area residents. Five local facilitators have been trained with full-scale implementation of the program beginning this fall. UW Carbone Cancer Center also has plans to expand the program to other rural counties in the future.”

‘The members of ACCAT have demonstrated that local leaders can achieve health improvements when they work together,’ said Rebecca Linskens, Outreach Specialist at UW Carbone Cancer Center. ‘I’m proud of what they have accomplished in Adams County.’”

“The pilot project has resulted in additional progress. After the project was featured as an example of an effective community-academic partnership at a Wisconsin Rural Health Development Council meeting in 2012, ACCAT was awarded another grant. The three year, $400,000 implementation grant from the Wisconsin Partnership Program will fund the first chronic disease navigation program based in a Wisconsin county public health office. The program was launched on October 12. It will fund a nurse and a community health worker who will help local residents navigate through the health care system.”

“ACCAT’s achievements were recently recognized at a statewide level when they were presented with a 2013 Community Service Award by the Wisconsin Cancer Council. The council is a coalition of over 95 organizations committed to cancer control ranging from health care providers and quality improvement organizations to academic and research institutions. ACCAT’s founding members were present to receive the award including Sarah Grosshuesch of Adams County Public Health, Mary Ann Schilling of Adams County UW-Extension, Maureen Bruce and Tammy Lowrey of Moundview Memorial Hospital & Clinics and Carol Johnson a community representative.”

‘ACCAT is honored to receive an award from the Wisconsin Cancer Council,’ said Maureen Bruce, Quality Director at Moundview Memorial Hospital & Clinics. ‘Since ACCAT began, our goal has been to create cancer prevention programs that can be sustained in our community. We have greatly benefited from our partnership with UW Carbone Cancer Center. And, our local organizations have developed a closer relationship by focusing on common goals.’”

‘Health care has evolved,’ added Jeremy Normington, CEO at Moundview Memorial Hospital. ‘There is an increased focus on prevention, wellness and the overall health of the community. When local organizations work together to address a wide-spread need, such as cancer prevention, change can happen. We believe we can make a difference in the health of our area residents.’”

23rd Annual $2,500 Monato Essay Prize
A $2,500 Prize for the Best Rural Health Paper by a University of Wisconsin student or recent graduate. Write on a rural health topic for a class and submit by June 1st. Submission info available at www.RWHC.com

For more information, contact Sarah Grosshuesch at Adams County Public Health, (608) 339-4379.
Just for a Moment…

By Cella Janisch-Hartline, RWHC Nurse Consultant:

For just a moment, please let me bend your ear about RWHC’s Nurse Residency Program. Excitement is building in the air as we get ready to kick off year 10 of this powerful, life-changing experience for the new nurse. So give me just a moment to refresh you about the program.

The RWHC Nurse Residency Program is a one year program structured around monthly learning experiences, where the new nurse is highly engaged in an interactive, reflective and enriched learning environment. The monthly sessions in Sauk City are designed around an effective standard curriculum for the nurse who is often isolated or is regularly challenged by minimal resources on the unit which is evident in rural health care.

Small group breakout sessions are incorporated into each learning day and are facilitated around the action reflection model of practice incorporating a high level of professionalism and dialoging around the standards of care and practice. Throughout the year long experience the new nurse is reminded time and time again that they get to choose many times a day while in practice what kind of nurse they are going to be.

Over this program’s tenure we have grown significantly, so much so that we now have to offer two cohorts each year because of size/space limitations. To date, this program has touched the lives and practice of 385 nurses through Year 9. Year 10 is on track to be the largest group to go through the program in one year.

Historically, turnover for the new graduate nurse is at the highest risk during the first year of practice. Inside the first year of practice there are additional statistics that show that this group of individuals are at the highest risk for leaving your organization at the quarterly marks of three, six, nine and twelve months. Many of those nurses who choose to leave their first nursing job, leave the nursing profession forever.

Yes you read right, forever. This may go without saying, but we need each and every nurse to stay in the profession to help us care for our aging population and to help fill the huge practice gap that will be present as the baby boomers retire. As, we reflect on the tenure of this program and the high turnover rate historically, I am pleased to report that through 9 years of the program our retention rate of keeping them in practice within our organizations for the year is at 93%.

This in itself pays for the nominal fee to participate in this program as the cost of turnover far outweighs the program cost per nurse.

A recent article I read indicated that the average cost of replacing a nurse and retraining another one is now at the outstanding cost of $90,000. I would venture to guess that in rural health care this number would be even higher because of the cross-training that needs to occur to cover the continuum of care with a flexible staffing model.

Just for a moment, I would like those organizations who have not participated in the program for awhile, or ever, to heavily reconsider this dynamic, interactive, highly stimulating, life changing program for your new nurses.

The investment in these new nurses up front will pay great dividends in the future for your organization and healthcare overall. For those of you who have demonstrated unending trust and commitment to this program, thank you for your ongoing support.

I am always willing to talk more about this program so feel free to call me at 608-644-3235 or e-mail me at chartline@rwhc.com.

Thanks for taking a moment.

Support NRHA Rural Leadership Development

The National Rural Health Association has launched a permanent endowment for programs that identify emerging leaders from and for rural communities. The mission is to provide training and resources to help them play a lead role in ensuring access to quality health care for rural Americans.

Go to http://ow.ly/ejmLf to learn more.
Leadership Insights: “Ego”

The following is from RWHC’s Leadership Insights newsletter by Jo Anne Preston, RWHC Organizational Development Manager. Go to www.RWHC.com for back issues.

“Donald Trump to the Dalai Lama, the influence of ego is a force we all face…and not just once, but most days, many times a day. Even the most enlightened beings will have a battle with their ego from time to time. Being thought of as arrogant, self-absorbed or ego-maniac is not how most of us want to be described, and it is very difficult feedback to hear—or to give to someone else. Your ego might be rearing its unappealing head if you find yourself:

- irritated with or jealous of a colleague’s success
- mentally or verbally downplaying another’s talents
- seeking recognition
- not listening because you are waiting to interrupt
- deciding that someone is wrong and you are right even before you know the whole situation
- stewing excessively over your mistakes
- thinking that the people around you are dimwits
- making self-deprecating comments that you know are not sincere
- getting defensive when others give you feedback

“See yourself? Most likely you can join me in saying we all connect with something in this list at some point or another. At a recent RWHC workshop on ‘Walk the Talk Leadership Accountability,’ Dave Schneider, the very approachable and well-respected CEO of Langlade Hospital in Antigo, WI, got me thinking about this topic when he said, ‘You have to learn to leave ego at the door if you want to be an effective leader.’ So how do we throw out this uninvited guest called ego?”

Don’t confuse ego with strong self-confidence. “The irony is that many leaders will shy away from owning their self-confidence out of fear of looking egotistical. Self-confidence is about authentically accepting your strengths and weaknesses and not spinning a story about either of them. Self-confidence is the core that is not threatened by others’ success or ideas unlike your own. Longing for outside recognition or feeling envious may be signs that we need to acknowledge our strengths ourselves. Build your self-confidence by taking an honest inventory of your strengths and not-so-strong suits. Everyone has both. Look at yourself with a scientist mind (facts and data), not a judgment mind (I’m good/bad). Pay attention to those you see as confident but not an ego-maniac and observe how they exhibit that in behaviors.”

Establish credit. “Who do you need to thank today? Someone contributed something to whatever you are doing successfully. Make it a daily habit to humbly reflect on who inspired, taught, encouraged, supported, or nudged you. Find some way to pass on the credit.”

Consider alternatives. “If you tend to communicate decisively most of the time, this can work for you in some cases, but any strength overused can become a liability. As a leader, your decisiveness may be closing doors to others’ ideas or engagement. Once you make up your mind about something, consider at least 2 other alternatives. Ask your team to improve your idea in at least 2 ways.”

Transform your anger before any coaching. “If you are angry when someone doesn’t perform up to standard, that anger is a sign that you are taking things personally—EGO! Find a way to let go of the anger, and look at the situation from the perspective of wanting to help that person develop. Other peoples’ behavior is not about you. This doesn’t mean that you lower the standard. It means you communicate the standard and ex-
pectation clearly and objectively with constructive dialogue. Coaching is about growing people, not about putting them in their place.”

Work on accepting your mistakes.
“Humility in the face of mistakes is one thing that makes a leader accessible and real to people. Ego, on the other hand, bristles at talking about mistakes, hides them, or broods in a pot of self-absorption (I know this one too well). My strategy lately is to tell myself, ‘GET OVER YOURSELF.’ Another one is to imagine how you would treat a valued colleague if they made the same mistake, and replicate that compassion to yourself.

Give 5. “For 5 minutes of each day, help someone with something that benefits them, not you, and don’t tell anyone about it. Pay attention to how it makes you feel about yourself. This gets us out of our own head where ego resides.”

Volunteer for a project in which you do not have expertise. “It’s about staying curious. Even Einstein said that he wasn’t particularly talented, just passionately curious. Keep learning, seeking, and challenging what you believe and what you know. Ego is more comfortable ‘knowing for sure.’ Self-confidence means being open to new ideas, willing to learn and to be wrong at times. For a great take on being wrong listen to: ‘Kathryn Schulz On Being Wrong’ at http://ow.ly/rGmne.”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For info re the RWHC Leadership Series 2014 go to www.RWHC.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

Upcoming RWHC Leadership Programs

January 9: Walk the Talk: Leadership Accountability
January 22: Peer Today, Boss Tomorrow
February 27: Project Management for the Busy Manager
Go to www.rwhc.com/Services.aspx to register as well as to see other upcoming events.