Health Data to Be Useful Needs to Be Shared

From “Data Sharing Needed to Increase Quality and Decrease Costs” by John J. Frey III in the June 2014 issue of WMJ at www.wisconsinmedicalsociety.org:

“Immunizations are primary prevention. We all learned that in medical school. The first regularly recommended immunizations were against early 20th century killers like diphtheria, pertussis, and tetanus. They were successful for a variety of reasons, not the least of which was that universal immunization was a public health campaign that worked. Photos from the 1930s in the heart of the Depression show lines of kids presenting their arms for the shot or squirming away from the needles. During my clinical lifetime, we have seen the disappearance of polio, measles, rubella, H influenzae meningitis, and significant decreases in other communicable diseases. Younger doctors—those under 50—almost forget why we immunize patients against many diseases, since in many cases it is the consequences of those diseases rather than the diseases themselves that are the rationale for immunization. They not only have never seen the disease, but they have not seen the consequences.”

“Having a record of immunizations is crucial for both individual health and ‘herd immunity’ and we see how cracks in universal immunizations have led to outbreaks of pertussis, measles and other, now rare infections. When we all carried around little folded paper records of immunizations that had been received from a number of sources, the portability was great and it led to real communication between public health clinics and practices. Now with the onset of electronic data collection, we have new challenges. Patients don’t carry their own records; they rely on their doctors and the data systems to do that. But those data systems contain human flaws that require both fixes to the technical process and assurance that in this issue the human beings entering data into systems are doing it correctly. Mistakes lead to either under- or over-immunization. The latter creates unnecessary costs, while the former creates gaps that could lead to serious health consequences.”

“While electronic health records (EHRs) offer the opportunity to improve population management for chronic disease, they are not convincingly better on day-to-day quality. However, accurate universal reporting of immunization records may be the only current system of sharing electronic health information that works. If immunizations can be shared across platforms, why can’t other medical information equally crucial to health? Until that happens, maybe we all should carry with us little books with our health records and medications should we wander outside of our insurance network.”

“The Wisconsin Pharmacy Quality Collaborative is a program of the Pharmacy Society of Wisconsin that received an Innovation Award from Centers for Medicare & Medicaid Services to improve medication

“Leadership is Action, Not Position” - Donald McGannon (broadcasting industry pioneer)
management for the people of Wisconsin. The special article in this issue of the WMJ describes the project and its goals and makes the case—if one still needs to be made—that pharmacists will play a crucial role in improving quality and decreasing costs of care through collaboration with patients and physicians. Having expressed skepticism about the potential for EHRs to address quality and cost, I have no doubt that getting pharmacists more engaged with patient care can only add value to a system of medication management. And data from electronic health records are essential to the process. Keeping accurate medication lists will let pharmacists help us manage potential drug interactions, polypharmacy, and chronic diseases. The Collaborative needs physician involvement and commitment to make it work for everyone.”

Editors Note: The Wisconsin Statewide Health Information Network (WISHIN) is “leading the way to enable Health Information Exchange (HIE) in Wisconsin. As the state-designated entity for HIE, WISHIN is working to create a network that will give health care providers a secure system to access medical information where they need it—when they need it.” More information is available at www.wishin.org.

“Busy Doctors, Wasteful Spending”

From “Busy Doctors, Wasteful Spending” by Sandeep Jauhar in “The Opinion Pages” of The New York Times, 7/20/14:

“Of all the ways to limit health care costs, perhaps none is as popular as cutting payments to doctors. In recent years payment cuts have resulted in a sharp downturn in revenue for many hospitals and private practices. What this has meant for most physicians is that in order to maintain their income, they’ve had to see more patients. When you reduce the volume of air per breath, the only way to maintain ventilation is to breathe faster.”

“As our workdays have gotten busier, we doctors have had less time to devote to individual patients. An internist I know in private practice used to see 15 patients a day. ‘Now reimbursement is so low I have to see at least 30,’ he told me. ‘If I stay in the room more than 10 minutes, my assistant will call me and tell me to hurry up.’ ”

“Racing through patient encounters, we practice with an ever-present fear that we will miss something, hurt someone and open ourselves up to legal (not to mention moral) liability. To cope with the anxiety, we start to call in experts for problems that perhaps we could handle ourselves if we had more time to think through a case. The specialists, in turn, order more tests, scans and the like.”

“And therein lies the sad irony of the health cost containment paradigm in this country. There is no more wasteful entity in medicine than a rushed doctor. The Institute of Medicine, a federally funded research group in Washington, has estimated that wasteful health care spending—i.e., spending that does not improve health outcomes—costs about $750 billion in the United States every year. Excessive paperwork and administrative costs explain some of this waste, but unnecessary or inefficiently delivered services, especially in hospitals, account for by far the largest chunk. Total payments to physicians, in comparison, are much smaller, making up a fifth or less of the money this country spends on health care.”

“But even though physicians’ salaries account for a relatively small fraction of health care costs, physicians’ decisions may affect upward of 80 percent of total health spending. We order tests, prescribe drugs, hospitalize patients and—one of the costliest
decisions a doctor can make today—call specialists for help.”

“There are many downsides besides cost to having too many doctors on a case. Specialists’ recommendations are often contradictory. The kidney doctor advises careful hydration; the cardiologist advises discontinuing intravenous fluid. Because specialists aren’t paid to confer with each other or to coordinate care—although the Affordable Care Act is putting payment systems into place that will do just this—they often leave primary physicians without clear direction on what to do.”

“More important, patients don’t always require specialists. Patients, especially older adults, often have disease syndromes that cannot be compartmentalized into individual problems and are probably best managed by a good general physician. When specialists are called in, each is apt to view a problem through the lens of his specific expertise. Patients generally end up worse off. I have seen it over and over.”

“One of my patients went to the emergency room after swallowing a tiny fish bone. She told me about the experience when she came to see me. ‘They kept me down in that E.R. for two days!’ she said. ‘They did X-rays, EKGs, CAT scans, God knows what. They had an ear, nose and throat specialist come by. They called a pulmonologist. They told me to follow up with my cardiologist. I told them it had nothing to do with it. It was the fish!’ ”

“Health care costs must be contained, but cutting payments to doctors is a self-defeating strategy. Policy makers need to focus on the drivers of waste. And one of the most potent is when doctors reflexively call other doctors for help.”

“Sandeep Jauhar is a cardiologist and the author of the forthcoming memoir ‘Doctored: The Disillusionment of an American Physician.’ ”

From “Rural hospitals need the federal government” by Paul R. Bengtson in THE HILL’s “Congress Blog”, 7/15/14:

“Every week caregivers at Northeastern Vermont Regional Hospital are told by patients how they rely on our hospital for quality care close to home. Our patients see us as an ally in their path to well-being. With an aging, Medicare population and higher rates of chronic problems such as diabetes, heart problems and cancer, there is truly a fight for good health taking place in rural America. Caregivers at Northeastern Vermont Regional Hospital and I are proud to be allies in that fight, but we need the federal government to be our ally as well. Healthcare in rural America depends on the federal government as a reliable business partner.”

“Lately, that hasn’t been the case. While being asked to implement a wide variety of reforms, rural hospitals confront a toxic mix of outdated laws, increased expenses from mandated regulations and programs, higher labor costs due to the challenges of attracting health care professionals to rural areas, and a Congress that repeatedly raids federal funding for hospital care to pay for other programs. With more than 50 percent of rural hospital revenues coming from government sources, it is vital for the government to be a better ally in our fight for good health.”

“Luckily, there a few champions for rural health in Congress who recognize the crisis rural hospitals face in delivering health care to their communities. Sens. Tom Harkin (D-Iowa), John Barrasso (R-Wyo.), Pat Roberts (R-Kan.) and Al Franken (D-Minn.) introduced The Craig Thomas Rural Hospital and Provider Equity Act, which would provide crucial support and relief to rural hospitals. Our hospital stands with the American Hospital Association in supporting this leg-
islation that would extend critical rural provisions that have expired or are set to expire and implement new provisions that would benefit rural hospitals. The senators sponsoring this legislation honorably aim to correct misguided policies implemented or overlooked by the government. Rural America needs more allies like these senators in our fight for good health; passing this legislation would be a step in the right direction.”

“In Vermont, hospitals work with other community providers to ensure patients get the care they need. Together, we have implemented a pilot project to co-manage the care of cancer patients in our region, with oncology specialists and primary medical home clinicians and our board-certified palliative care physicians working as a team to provide the best possible care. We are about to embark on a demonstration project to co-manage the care of patients living in our region who qualify for Medicare and Medicaid. And we are redefining how health services are delivered. If it were not for the leadership policies recommended in the legislation, our ability to care for patients would not only be diminished, but in many cases, eliminated.”

“According to the U.S. census, nearly 20 percent of the U.S. population resides in rural areas. Rural hospitals see a higher percentage of inpatients aged 65 and older compared with their urban hospital counterparts. These citizens count on their community hospitals to provide health care services and add jobs to their local communities. Through partnership with the federal government, rural communities and their health care providers can continue to tackle the chronic problems facing patients across the country.”

Bengtson is CEO of Northeastern Vermont Regional Hospital and chairman of the AHA Section for Small or Rural Hospitals.

23rd Monato Rural Essay Winner Announced

The winner of RWHC’s 23rd Annual $2,500 Monato Essay Prize is “Microbial Perspective on Soil in Agriculture: How Soil Microbial Communities Can Be Used for Better Rural Health in the 21st Century” by Woojong Lee, a senior studying microbiology at the University of Wisconsin-Madison. Woojong was asked to share with us what his plans are going forward:

“After graduation, I am planning to pursue a Ph.D degree because doing research in science motivates me to work arduously to find a way to explain how and why biological phenomena work altogether. I have come to realize that I like to work in a laboratory setting independently as well as collaboratively. Most importantly, the professional research field is pivotal for me because the work I do helps researchers in similar lab areas and medical doctors who want to relieve or cure patients who are gravely ill. The diverse lab experiences have constantly reminded me why I want to do research.”

“As a researcher, I want to continue these fulfilling, exciting moments I had from working on studying cancer signaling pathways. To make more discoveries in this field, more scientists will be needed; I certainly want to be one of them. I am originally from Korea.”

Woojong Lee’s submission is more technical than past awardees. But it shares the common thread of all past winners in that a student is speaking up and adding to our understanding of what it takes for a healthier rural Wisconsin. The complete paper is available at www.RWHC.com; below is a brief excerpt:

“Our tendency to take soil for granted results in a perception that soil is nothing more than dirt. In fact, this perception is misleading, as soil and the organisms in it are what allow life on this planet to exist. Soil governs every aspect of life when we are not even thinking about it. The microorganisms residing in the soil, such as bacteria, fungi and protozoa, constantly drive all necessary chemical cycling on Earth by recycling nutrients, including carbon, nitrogen, and sulfur, which are essential for plant growth. A further fascinating function of soil is its role in regulating the cli-

Register for the November 12th “Building a Culture for Patient-Centered Team Based Care” conference sponsored by the Wisconsin Council on Medical Education and Workforce (WCMEW). Our purpose is to showcase successful health care teams with dialogue about how cooperation among health professionals leads to continuous improvement of patient care. Will be at the Glacier Canyon Lodge located in the Wisconsin Dells; register at http://ow.ly/Ad583.
mate system, by virtue of regulating carbon storage in the soil. Soil and soil microbes are therefore essential components of the ecosystem, because of their critical roles in regulating soil quality. Even though such pivotal roles have been extensively investigated, their importance has not been heavily promoted to, or perceived by the public, resulting in the deterioration of the public health in rural areas by destroying the quality of the soil, particularly from the use of pesticides.”

“The employment of bioremediation to soil that is polluted with POPs has many promising aspects because of its low cost and eco-friendliness. In the past, people often excavate and treat on site with soil washing, incinerate, or landfill to deal with toxicants in the soil. However, these traditional approaches are expensive and create other environmental xenobiotics that would degrade human health. For example, if we excavate the contaminated soil from a site and transport it for incineration, it will cost $400 per ton. On the other hand, if we treat the contaminated soil with microbes for bioremediation, it will only cost $80-$100 per ton, which makes it more cost-effective. Most importantly, if we burn those potentially hazardous chemicals and blow them into the atmosphere, more toxic forms of the chemicals would be generated as a result of incineration of POPs and remain in the ecosystem.”

“However, if we approach soil pollution using bioaugmentation, we do not have to worry about disposal costs. Foremost, it will be a much more eco-friendly approach, as over 90% of the chemical substances classified as hazardous today can be biodegraded, and the end-products of biodegradation are generally not chemicals that are toxic to humans. Additionally, bioremediation does not spread chemicals through the soil or groundwater, since POPs would not be leached or transferred to another region.”

A $2,500 Prize for the Best Rural Health Paper by a University of Wisconsin student is given annually by RWHC’s Hermes Monato, Jr. Memorial Fund--write on a rural health topic for a regular class and submit a copy by June 1st. Go to www.RWHC.com for more information.

2014 Kristi Hund Award Winners

Tim Size, Executive Director of the Rural Wisconsin Health Cooperative (RWHC), recently announced the recipients of the 2014 Kristi Hund Awards: Heather Kleinbrook from Stoughton Hospital in Stoughton, WI, received the Kristi Hund Award for Excellence in Nursing Leadership. Ramona Borgmann from Monroe Clinic in Monroe, WI, received the Kristi Hund Award for Nurse Excellence.

From Heathers’s nomination…. It is with great enthusiasm that we nominate Heather Kleinbrook, Geriatric Psychiatry Manager at Stoughton Hospital as RWHC Nurse Excellence in Leadership Award. Heather is our organization’s expert related to patients with mental health needs. She provides leadership and defines practice to not only the Geriatric Psychiatry department but also to other clinical areas of the hospital including the ED. She knows the legal aspects as well as potential resource options available to our patients. Heather sets the standards for the nursing practice on Geri-psych and excels above and beyond her peers. She has taken the initiative to attain the Psychiatric and Mental Health Nurse Certification and promote evidence-based best practice.

Heather holds high practice standards and expects the same of others. She sets the policies and procedures related to Geri-psych in collaboration with the staff and evidence-based practice findings. In regards to the National Patient Safety Goals, Heather is our expert related to restraint and seclusion regulations and has done extensive work to help eliminate the usage of restraints and seclusion at Stoughton Hospital. Heather is also an active member of the Patient
Safety Committee so involved with the integration of all of the National Patient Safety goals house-wide.

From Romona’s nomination…. Ramona demonstrates excellence in nursing practice in many ways. She is currently an active participant in our preceptor and certification track and also serves as a Preceptor Track Steering Team member within our Professional Development Program. The main goal of this steering team is to standardize and set expectations for all new RN’s hired within the organization. As part of the preceptor track she also has been instrumental in developing the Core RN competency orientation checklist as well as the department-specific orientation checklist.

Ramona surpasses most of her peers in her profession because of her involvement in several process improvement committees. She assists in creating and maintaining several of the departmental competencies. Ramona demonstrates her own accountability for her practice. For example, the Oncology department performs an annual competency on the safe use of the lift devices used in the organization. Ramona ensures her own competency with the lift devices by partnering with Physical Therapy to receive additional training prior to providing education to the Oncology nursing staff. Ramona teaches a Central Venous Access Device Class for all Registered Nurses on a quarterly basis. This class was originally implemented because Ramona identified inconsistencies across the organization in central line care. She developed the class content to ensure standardization across all settings within the organization including Home Care, Inpatient and Outpatient Services. Ramona also assists in teaching a 2-day preceptor workshop on an as needed basis.

According to Size, the former Nurse Excellence Awards were initiated to recognize high quality nursing practice provided by the hospitals serving rural communities. Nurses in community hospital settings must be well educated, well rounded at clinical practice, and have the ability to respond to a variety of age groups, diagnoses, and patient emergencies. Establishment of this award is public recognition that excellence in nursing practice is a valuable asset to rural communities and the state of Wisconsin.

Nurse Residency Program Enrollment Open

The RWHC Nurse Residency Program is a twelve-month structured program offering support for the nurse graduate through monthly learning days and the support of an experienced nurse, a Clinical Coach. The goals of the program are to help the nurse resident:

• Transition successfully to a competent practitioner
• Enhance his/her ability to provide quality, evidence-based care
• Advance critical thinking ability
• Improve skills in clinical decision-making
• Commit to life-long learning
• Engage in a clinical nurse leadership role

The RWHC Nurse Residency Program is a one year program structured around monthly learning sessions, where the new graduate nurse is highly engaged in an interactive, reflective and enriched learning environment. The sessions are designed around an effective standard curriculum for the rural nurse who is often isolated on a unit with minimal resources. Learning needs identified by the participants are also weaved in to each learning session. Networking with peers who are going through the same challenges is a powerful experience for the new nurse. Small group breakout sessions are incorporated into each learning day and are facilitated with the action reflection practice model incorporating the accepted standards of practice.

Curriculum Acknowledgment: The fundamental basis of this programs’ curriculum originated through the collaborative work between Marquette University and
several Wisconsin urban and rural health care partners who ultimately developed The Wisconsin Nurse Residency Program. At the time of origination this program was coordinated via the outstanding visionary, Marilyn Meyer Bratt, PhD, RN, Associate Professor of Marquette University and was federally funded for three years through HRSA (Health Resources and Services Administration).

The next cohort begins on October 28, 2004. Please contact the RWHC Program Coordinator, Cella Janisch-Hartline, RN, BSN, for more details at 608-643-2343 or chartline@rwhc.com.

Leadership Insights: “Managing”

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

“There are many writings on the distinction between management and leadership. Wherever you land on defining them, both are important and necessary. Both also have ever-evolving best practices, and as managers and leaders (titled or not) we must also be ever-evolving. If we don’t grow, we risk becoming obsolete and unable to attract and keep an excellent workforce—a workforce which also is changing.”

“Management may not be as ‘exciting’ as leadership, but without good management, chaos reigns. John Kotter, author of Leading Change and international leader in change research, states that we need about 70% leadership (movement, vision) and 30% management (order, maintenance) to be successful at our change efforts. If you have ever followed a leader who lacked management resources and skills, it feels like you are taking flight without wings and fuel. Following a manager without leadership abilities is like you are never allowed to get off the tarmac. There is a natural tension between leadership and management and when we get the balance right, it is like nature’s elements of earth, fire, water and air all sustaining life (vs. earthquakes, raging fires, floods and cyclones that destroy).”

Start by considering how effectively you are managing YOU. “Before we can manage a group of others we must look at our own projects and workload. If you are too frequently overwhelmed, missing deadlines, can’t find things, it’s time to put some systems in place for yourself. Some simple time and energy management techniques can help:

1. Do you know your prime time, when you are at your best? Figure that out and schedule your most mentally challenging work during those times.

2. Unapologetically build in planning time. If you don’t have something structured, start with a regular half hour on the first and last day of your work week for bigger picture plans, and 5 minutes at the beginning and end of each day for today’s and tomorrow’s plans. Be unapologetic in assertively claiming time for this, even in the face of demands from others. When we move from individual contributor to a manager role, planning feels like we are not ‘producing,’ not as busy as others, and many managers are not comfortable with this. Planning effectively is a task of a manager. Claim it and put it on your list. It is not only important to spend dedicated planning time, but it also models to others that this is a valued practice that you support for them as well.

3. Have 45 minute meetings. Shorter is fine too! But if you typically schedule one hour meetings, and they are back to back, after the first hour you are running late all day. If it is not your call, ask for organizational support for this idea to give everyone the space to recalibrate between meetings (the asking shows leadership). This allows for physical health benefits too: we move, we get to go to the
restroom, get a glass of water, all things that we sacrifice when we run late.”

Get familiar with key data points about your work. “Why? Data is your friend, even if you are not a numbers person–actually, especially if you are not a numbers person. What are the major drivers of success for your projects and staff? Once your leadership vision defines where you are headed, identify the top 2-3 markers or numbers that will tell you if you are on the right track. There will be way more than 2-3 you could look at in many cases, but if you learn and KNOW the top 2-3 you can course correct faster and you will be paying attention to the most important things when there isn’t enough time to do everything.”

Establish some rituals. “Much like families in chaos, having something that you can count on in times of change can build resilience by managing what you can manage. Some teams do a structured ‘huddle’ at the start of the day to connect all actions to purpose. Great teams build in and commit to regular recognition of each other at the beginning of every team meeting as a way of actively building a culture of appreciation. What are some rituals you could build in at work that will help you manage you and your team?”

Contact Jo Anne Preston for individual or group coaching at jpreston@RWHC.com or 608-644-3261. For Info re the RWHC Leadership Series 2013 go to www.RWHC.com and click on “Services” or contact RWHC Education Coordinator Carrie Ballweg at cballweg@RWHC.com or 608-643-2343.

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October 7: Speak Up! Developing Public Speaking and Presentation Skills  
October 9: At The Heart of the Matter: Engaging Your Workforce  
October 22: Coaching for Performance

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